



# THE UNIVERSITY *of* EDINBURGH

This thesis has been submitted in fulfilment of the requirements for a postgraduate degree (e.g. PhD, MPhil, DClinPsychol) at the University of Edinburgh. Please note the following terms and conditions of use:

This work is protected by copyright and other intellectual property rights, which are retained by the thesis author, unless otherwise stated.

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge.

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author.

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.



THE UNIVERSITY *of* EDINBURGH

**Exploring recovery from severe  
and enduring mental illness using  
qualitative methods: A portfolio thesis**

Simon Robertson Stuart

Submitted in part fulfilment of the degree of  
Doctorate in Clinical Psychology  
at the University of Edinburgh, May 2015

**D.CLIN. PSYCHOL.  
UNIVERSITY OF EDINBURGH / NHS (SCOTLAND)  
TRAINING PROGRAMME**



**Front sheet / Title Page for Submitted Academic Work**

TRAINEE NAME: **Simon Stuart**

TITLE OF SUBMISSION:

**Exploring recovery from severe and enduring mental illness using qualitative methods: a portfolio thesis**

COURSE SUBMITTED FOR (please tick relevant box):

	CP1	CP2
Case conceptualisation (CP1 and CP2)	<input type="checkbox"/>	<input type="checkbox"/>
	3	4
Case study (only for those starting pre 2009)	<input type="checkbox"/>	<input type="checkbox"/>
	OA/Neuro	Child
Essay questions (only for those starting pre 2009)	<input type="checkbox"/>	<input type="checkbox"/>
Research proposal (R1)		<input type="checkbox"/>
Small scale research project (R2)		<input type="checkbox"/>
Small scale research project 2 (only for those starting pre 2009)		<input type="checkbox"/>
<b>Thesis</b>		<input checked="" type="checkbox"/>

*Submitted in part fulfilment of the degree of doctorate in Clinical Psychology at the University of Edinburgh*

*Date Submitted: **1 May 2015***

## D. Clin. Psychol. Declaration of own work

*This sheet must be filled in (each box ticked to show that the condition has been met), signed and dated, and included with all assignments - work will not be marked unless this is done*

**Name: Simon Stuart**

**Assessed work: Thesis**

**Title of work: Exploring recovery from severe and enduring mental illness using qualitative methods: a portfolio thesis**


*I confirm that all this work is my own except where indicated, and that I have:*

- Read and understood the Plagiarism Rules and Regulations ☒
- Composed and undertaken the work myself ☒
- Clearly referenced/listed all sources as appropriate ☒
- Referenced and put in inverted commas any quoted text of more than three words (from books, web, etc) ☒
- Given the sources of all pictures, data etc. that are not my own ☒
- Not made undue use of essay(s) of any other student(s) either past or present (or where used, this has been referenced appropriately) ☒
- Not sought or used the help of any external professional agencies for the work (or where used, this has been referenced appropriately) ☒
- Not submitted the work for any other degree or professional qualification except as specified ☒
- Acknowledged in appropriate places any help that I have received from others (e.g. fellow students, technicians, statisticians, external sources) ☒
- Complied with other plagiarism criteria specified in the Programme Handbook ☒
- I understand that any false claim for this work will be penalised in accordance with the University regulations ☒
- (For R2 & Thesis) Received ethical approval from the University of Edinburgh, School of Health ☒

OR

- (For R2 & Thesis) Received ethical approval from an approved external body and registered this application and confirmation of approval with the University of Edinburgh's School of Health's ethical committee ☒

**Signature**



**Date 1 May 2015**



## **Acknowledgements**

First and foremost, my heartfelt thanks to the eight people who agreed to share their experiences of recovery after forensic secure care. I hope that the finished article is representative of your voices, and I hope that those voices will continue to be heard. Thank you to the colleagues who helped recruit participants to the project: Helen, Bruce and John for making time, no matter how busy you were, and Alistair and Susi for helping to get it off the ground in the first place.

My supervisors, Dr Ethel Quayle and Dr Louise Tansey, have been tireless sources of advice, support and expert constructive criticism, and I am profoundly indebted to them.

A wealth of others have offered encouragement and inspiration, both directly and indirectly. There are too many to name, but this seems a fitting juncture to offer particular thanks to three deeply valued friends and colleagues: Chris Graham, Nick Earley and Patrick Doyle.

Finally, and eternally, my love and gratitude to my partner, Fiona Brown ... for everything.

## **Thesis table of contents**

Chapters 2 and 3 each have an additional list of contents on their respective opening pages.

<b>Abstract .....</b>	<b>1</b>
<b>Chapter 1: Portfolio introduction.....</b>	<b>2</b>
<b>Chapter 2: Systematic review .....</b>	<b>5</b>
<b>Chapter 3: IPA study .....</b>	<b>44</b>
<b>Chapter 4: Extended method .....</b>	<b>86</b>
<b>Chapter 5: Contextual reflection .....</b>	<b>94</b>
<b>References for full thesis.....</b>	<b>100</b>
<b>Appendices .....</b>	<b>108</b>

### List of tables and figures

Table 1: CHIME themes (systematic review) .....	9
Table 2: Comprehensive summary of papers reviewed (systematic review).....	17
Table 3: Quality ratings of papers reviewed (systematic review).....	25
Table 4: Additional themes (systematic review).....	27
Table 5: Master themes by coding density (systematic review) .....	28
Table 6: % of each paper accounted for by master themes (systematic review) .....	29
Table 7: Themes and superordinate themes, by participant (IPA study) .....	54
Figure 1: Flowchart showing appraisal and selection of papers (systematic review).....	14

### List of appendices

1. The Journal of Psychiatric and Mental Health Nursing (journal information) .....	108
2. Articles excluded from systematic review based on full-text reading .....	109
3. Quality assessment tool for systematic review .....	111
4. Qualitative Health Research (journal information).....	122
5. Semi-structured interview schedule .....	123
6. Participant information sheet .....	124
7. Participant consent form .....	126
8. Ethical and other approval .....	127
9. Transcription conventions.....	136
10. Example of IPA transcript.....	137
11. Clinical Psychology Forum (journal information).....	138

Word count for main body of thesis: 28,879

# **Exploring recovery from severe and enduring mental illness using qualitative methods: A portfolio thesis**

## **Abstract**

This thesis offers a critical consideration of the recovery approach to severe and enduring mental-health problems (Roberts & Boardman, 2013; Anthony, 1993), with the primary-research element focused on recovery after forensic secure care. A systematic review of qualitative research into recovery processes was conducted, using best-fit framework synthesis as a method of analysis (chapter 2). An expansion of the CHIME recovery model (Leamy et al., 2011) is proposed, in which the difficulties experienced by service users are more prominently considered. Chapters 3 and 4 report an investigation of the barriers to recovery perceived by people discharged from forensic secure care, using interpretative phenomenological analysis as a method (Smith et al., 2009). Eight participants were interviewed, and five superordinate themes are proposed: living in the shadow of the past, power imbalances, security and care, reconfigured relationships, and ‘recovery’ as a barrier to recovery. The final chapter of the portfolio is a shorter reflective paper considering the wider context of the work.

## Chapter 1

### Introduction to the portfolio thesis

#### Recovery: a brief overview

The recovery approach within mental-health treatment is frequently defined as ‘a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles ... a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness’ (Anthony, 1993, p.527) – or ‘the quote by Anthony which everyone deploys’ (Rose, 2014). Diana Rose’s scepticism appears well placed. Professor of user-led research at King’s College London, Rose is both expert academic and expert by experience – someone with lived experience of mental ill-health and of treatment by NHS services in the UK. As the title of her 2014 polemic, *The Mainstreaming of Recovery*, makes clear, her concern is that a progressive, alternative idea, created and once owned by service users, is becoming the property solely of services.

The recovery movement began in the 1970s as an advocacy approach by former patients – or ‘survivors’ – of mental-health services, who argued that they and others like them were entitled to a life beyond the stigmatising label of being a ‘mental patient’ (Davidson & Roe, 2007). Recovery offered an alternative to the dominant psychiatric model of rehabilitation (Deegan, 1988): it suggested that people might set goals on their own terms, using their own definitions. In 2015, recovery has become part of the mainstream to the extent that it is an aspect of national mental-health policy (Scottish Government, 2012), albeit without clear guidance as to how it should be implemented in different services. Nonetheless, mental-health professionals are encouraged to consider not only clinical outcomes but personal and social ones. Not all personal and social outcomes, however, are equal – as Rose (2014) argues, even the most recovery-focused service is unlikely to accept a service user stating that they aspire to go to bed for a month. As such, responsibility for – and control of – recovery appears to have passed from service users to services (Arenella, 2015).

Admirable professional attempts have been made to frame recovery scientifically (Leamy et al., 2011; Warner, 2010), and to develop validated measures which services can use (Monger et al., 2013). As the Systematic Review chapter of this thesis demonstrates, high-quality qualitative research also exists which explores the meaning of recovery for service users in their own words. However, as Rose (2014) cautions, much of the evidence concerns people who are deemed to have ‘recovered’, and we know less about the experiences of people who maybe continue to struggle. Originally, the recovery movement stood in opposition to

individualised notions of success and cure (Deegan, 1988). If we celebrate only the stories of those deemed by professionals to have recovered, we risk rendering the original concept meaningless (Onken et al., 2007).

### A brief introduction to this thesis

The original aim of this thesis was to explore the meaning of recovery with a group of people whose voices may be among the least frequently heard in society: former inpatients of a forensic secure unit, in this case a medium-secure facility in Scotland. The lead author, SRS, is a trainee clinical psychologist with a particular interest in community-psychology approaches, aligned to a forensic service as part of his doctoral programme. The secure unit to which he was attached had for some time employed principles of the recovery approach, but no formal research had been carried out to evaluate this or to explore it within a psychological paradigm. While a small body of research exists examining the applicability of recovery to a forensic population, there are many potential obstacles to its achievement (Simpson & Penney, 2011); furthermore, very few studies have examined what recovery might mean to people discharged from secure care, or how challenging it might be. This was the basic rationale for the primary-research element of this thesis (chapter 3), a qualitative exploration of the barriers to recovery perceived by former forensic inpatients, using interpretative phenomenological analysis (IPA; Smith, Flowers, & Larkin, 2009). It is anticipated that this will be of particular interest to anyone wishing to understand more about the applicability of the recovery approach within a forensic service, or who has an interest in service users' perceptions of recovery.

While the research process was still in the early stages, it became apparent that, although there was a body of qualitative literature exploring service users' experiences of recovery in various settings, this varied considerably in quality and approach. Furthermore, 'recovery' was used liberally as a term within published studies exploring problems including severe and enduring mental illness, more moderate mental-health problems, substance abuse and domestic violence: a breadth in keeping with the general recovery ethos, but problematic in terms of trying to review the literature. Thus arose the idea for the other research chapter of this thesis: a systematic review of qualitative recovery literature as it pertains to severe and enduring mental illness (chapter 2). The valuable contribution of qualitative evidence to healthcare research is increasingly recognised (Dixon-Woods et al., 2004), and where a strongly individual concept such as recovery is concerned, it may in fact be optimal. Various analytical approaches exist to facilitate the synthesis of qualitative literature, among them

best-fit framework synthesis (Carroll et al., 2011, Dixon-Woods, 2011). This relatively novel method was chosen for two key reasons: first, it allowed for a consideration of recovery processes with direct recourse to other recent research in the area (Leamy et al., 2011); second, it may allow for high-quality work to be carried out despite strictures of time and resources (Dixon-Woods, 2011), an important consideration for a clinical-psychology doctoral thesis.

The thesis contains two additional chapters. Chapter 4 is an extension of the methodology section within chapter 3, providing a more detailed critical rationale for the use of IPA.. Chapter 5 is also a function of the use of IPA: a reflective and contextual chapter allowing the lead author the opportunity to discuss and consider more deeply his motivations for carrying out this research, and the biases he may have brought to it.

Chapter 2

**What do we know about how service users with severe and enduring mental illness experience the process of recovery?  
A systematic review and best-fit framework synthesis  
of qualitative literature.**

Simon R. Stuart\*, MA, MSc  
Louise Tansey, PsychD  
Ethel Quayle, PsychD

Department of Clinical Psychology, School of Health in Social Science, University of  
Edinburgh, Teviot Place, Edinburgh EH8 9AG, Scotland

\*Corresponding author. Address as above.  
E-mail: [simonstuart@nhs.net](mailto:simonstuart@nhs.net). Tel: 0131 537 6913

**Contents**

<b>Abstract.....</b>	<b>6</b>
<b>Introduction .....</b>	<b>7</b>
<b>Method .....</b>	<b>12</b>
<b>Results .....</b>	<b>16</b>
<b>Discussion.....</b>	<b>34</b>
<b>References .....</b>	<b>39</b>

This article has been prepared in line with the publication guidelines for the Journal of Psychiatric and Mental Health Nursing, adapted for coursework submission to the University of Edinburgh Department of Clinical Psychology. Information about the journal, including author guidelines, is included in Appendix 1.

**Word count, excluding contents, tables, references and appendices: 7689**

# **What do we know about how service users with severe and enduring mental illness experience the process of recovery?**

## **A systematic review and best-fit framework synthesis of qualitative literature.**

### **Abstract**

The recovery approach is increasingly popular among mainstream mental-health services, but it has been criticised as ambiguous (Beresford, 2015). Although efforts exist to formally conceptualise it, with the CHIME model offering a promising framework (Leamy *et al.*, 2011), there remains a lack of consensus over the applicability of the recovery approach. An analysis of existing qualitative research might be of use in clarifying what recovery means to service users. This review systematically identified peer-reviewed qualitative research into people's experiences of recovery, and assessed the quality of 15 journal articles. Twelve of these were subsequently analysed using best-fit framework synthesis (Carroll *et al.*, 2013), with the CHIME model of Leamy *et al.* (2011) providing the exploratory framework. An expanded conceptualisation of recovery is proposed, in which the difficulties experienced by service users are more prominently considered. Clinical implications are discussed, in particular the risk that an overly optimistic, professionally imposed view of recovery might serve to homogenise or even blame individuals rather than empower them.

**Keywords:** Mental illness, recovery, review, qualitative, severe, systematic.

### **Accessible summary**

#### **What is known on the subject:**

- People disagree about what recovery from mental illness means.
- Some doctors, nurses and other professionals have asked service users about recovery.

#### **What this paper adds to existing knowledge:**

- This paper examines that research, and brings together the results.
- It looks at how the results fit with the way some professionals view recovery.

#### **What are the implications for practice:**

- Professionals might think that recovery from mental illness is easier than it really is.
- We need to make sure we don't force our own ideas on service users.



## 1. Introduction

### 1.1 What is recovery?

Recovery from serious mental illness is not a straightforward concept. In a review of terminology, Davidson and Roe (2007) argue that recovery has become a conflation of two ideas: clinical recovery, or ‘recovery from’, defined broadly by the amelioration of symptoms and a move towards what might be deemed normal functioning; and a consumer-focused definition, which they call ‘recovery in’. By this second conceptualisation, popularised by Deegan (1988), symptomatology can still be present and recovery is defined subjectively as an overcoming of difficulties to an extent that a person feels they have regained some control over their life. Pilgrim (2008) broadens this into a trichotomy of recovery: a biomedical/treatment approach about recovery from illness, a psychiatric/rehabilitation approach about recovery from impairment, and a consumer/survivor approach about recovery from invalidation.

Anthony (1993) explored how the principles outlined by Deegan (1988) might be adopted by mental-health services through a focus not just on treatment but on collaborative efforts to develop and empower, giving rise to what has become popularised as the recovery model or recovery approach, based on the consumer and survivor definitions above. In a systematic review of theoretical, empirical and review-based literature – albeit one in which quality was not appraised – Stickley and Wright (2011) identified salient themes including hope, optimism and meaningful social activity. While they proposed that empirical research would be key to clarifying recovery theoretically and practically, there remains a lack of consensus about exactly what constitutes successful recovery within this paradigm, leading to criticisms of the concept as ambiguous and unclear (Beresford, 2015).

Nevertheless, the recovery approach has gained traction among professionals, services and decision-makers (Bradstreet & McBrierty, 2012; Roberts & Boardman, 2013), perhaps because it offers a collaborative and optimistic paradigm in which to work with service users. It was enshrined in the Mental Health Strategy for Scotland 2012-2015 (Scottish Government, 2012), which suggests that recovery involves looking beyond clinical measures and considering individuals’ social and personal outcomes. However, implementation of such an approach may prove challenging: in the UK National Health Service, for instance, established mental-health services retain a focus on treatment and reduction of risk (Stickley & Wright, 2011). Questions about the fundamental responsibility of services – to treat or to empower? – therefore become more pressing as the recovery ethos gains sway. Similarly, it

is not always clear for whom the recovery approach is intended. Anthony (1993) considered recovery in relation to people with severe and enduring mental illness, for example a diagnosis of schizophrenia, but the concept has been broadened to include such diagnoses as depression and first-episode psychosis (Stickley & Wright, 2011). From an implementation perspective, the recovery approach can therefore appear to be a general and vague philosophy of care (Smith-Merry *et al.*, 2011).

## 1.2 Operationalising recovery, and CHIME

Various attempts have been made to summarise or encapsulate key elements of recovery. Warner (2010) offers a brief review of selective literature, concluding that empowerment is a salient factor, and that employment may be a way of increasing this. Roberts and Boardman (2013) provide a considered analysis of the ideas and principles of the contemporary recovery approach, suggesting that the principal factors are hope, control and opportunity: nevertheless, this is a commentary rather than a comprehensive review. Andresen *et al.* (2003) and Bonney and Stickley (2008) offer thematic summaries based on reviews of existing literature, but in both cases the selection of articles appears more subjective than systematic, and methods of analysis are unclear. Brown & Kandirikirira (2007) provide a lengthy report based on the narratives of 64 people in Scotland who identified themselves as being in recovery, from which the authors draw an explicit division between internal elements of recovery (for example meaningful activity and belief in oneself) and external ones (e.g. appropriate formal and community support). Once again, however, the method of analysis is unclear: furthermore, this is a non-peer-reviewed document which aimed to promote discussion, rather than provide scientific analysis.

A more rigorous review is that of Leamy *et al.* (2007). This is based on a systematic analysis of 97 published conceptualisations of recovery from mental illness, with service-user input into the final modelling. The authors present three overlapping models: characteristics of the recovery journey, proposed recovery stages and, primarily, a framework for recovery processes given the acronym CHIME (Table 1). Leamy *et al.* (2011) state that the CHIME processes have relevance to clinical research and practice, and Slade *et al.* (2012b) cite CHIME as providing a flexible empirical underpinning for further research. The CHIME model has been used within various studies by the research group that created it: Shanks *et al.* (2013) employed it as a way of validating pre-existing measures of recovery, while Slade *et al.* (2015, 2011) state that it informed aspects of the design of a randomised control trial to explore the value of a recovery-focused intervention carried out with mental-health staff.

However, the only CHIME elements considered among the outcome measures appear to be hope and empowerment. Williams *et al.* (2015) used CHIME as a framework for creating one aspect of a measure of staff support for recovery. This was psychometrically evaluated with data from 92 service users, although the reporting of the exploratory factor analysis is unclear: the pattern of correlations observed for the Empowerment domain appears unreliable, but the authors nevertheless suggest that a five-factor CHIME-based approach was appropriate for the measure.

Table 1: The CHIME master themes and subthemes (Leamy *et al.*, 2011).

Master theme	Subthemes
<b>Connectedness</b>	Peer support and support groups Relationships Support from others Being part of the community
<b>Hope and optimism about the future</b>	Belief in possibility of recovery Motivation to change Hope-inspiring relationships Positive thinking and valuing success Having dreams and aspirations
<b>Identity</b>	Dimensions of identity Rebuilding/redefining positive sense of identity Overcoming stigma
<b>Meaning in life</b>	Meaning of mental illness experiences Spirituality Quality of life Meaningful life and social roles Meaningful life and social goals Rebuilding life
<b>Empowerment</b>	Personal responsibility Control over life Focusing upon strengths

A validation study of CHIME itself has also been produced (Bird *et al.*, 2014), based on thematic analysis of qualitative data from focus groups made up of NHS service users (N=48) with diagnoses including schizophrenia, bipolar disorder and depression. This supported the existing category structure but highlighted areas that were not included within CHIME, including a desire for practical support (which the authors suggested might fit within Connectedness), issues around diagnosis and medication, and scepticism from some people about the concept of recovery. This is pertinent, given that it has been observed that the CHIME categories tend towards the positive or optimistic (Connell *et al.*, 2014). While it is arguable that some of the themes could be bidirectional and indicate loss as well as gain

(e.g. a person's sense of Connectedness or Meaning could be reduced), it is not clear that this was the authors' aim, and several subthemes are very positively worded (Table 1).

Independent researchers have also considered and in some cases adopted CHIME. Wyder and Bland (2014), in an essay considering families' responses to mental illness, highlight the comparative succinctness of the model, and Shepherd (2013) notes that CHIME provides a conceptual clarity that may be of value in empirical studies. The model was incorporated into a qualitative study of service users' relationships with professionals (Eriksen *et al.*, 2014). Brijnath (2015) carried out a framework-type qualitative analysis to explore the cross-cultural applicability of CHIME, considering recovery from depression in two culturally diverse groups, Anglo-Australians and Indian-Australians. The model appeared applicable to both, although cultural differences were observed: for example, respondents said that Connectedness was affected by different levels of social support, and Indian-Australians placed more importance on spirituality within the Identity domain. Across both groups, it was noted that within the Hope domain there appeared to be a desire for a full cure from depression, as opposed to the symptomatic recovery described by Anthony (1993).

### 1.3 Measuring recovery outcomes

While attempts are ongoing to produce reliable measures of individual recovery (Monger *et al.*, 2013), the validity of any such measure remains debatable. As might be expected for a concept in which symptom reduction is not paramount, correlations with traditional clinical measures of outcome may be poor (Andresen *et al.*, 2010) and convergent validity low. Indeed, construct validity in general appears a problem: if recovery is determined by each individual (Smith-Merry *et al.*, 2011), against what can it be normed, unless an external conceptualisation of recovery is imposed? Traditional approaches to quantification may be impractical where consumer-focused recovery is concerned (Browne, 2006), and researchers and services alike may require a more complex approach to personal narratives and construction of meaning (Roberts & Boardman, 2013). This has been recognised by the research group which constructed CHIME, who have proposed an individualised outcome measure with two components: goal attainment and personalised primary outcome (Pesola *et al.*, 2015). This is promising, but requires independent evaluation.

In terms of clinical measurement, initiatives such as Wellness Recovery Action Planning (WRAP; Cook *et al.*, 2009) – a service-user-designed, manualised and copyrighted recovery plan – have been adopted. The review of recovery implementation by Smith-Merry *et al.*

(2011) cautions that the risk with such approaches is that, despite their collaborative nature, their application remains controlled by services. This consolidates power and ultimately requires users to conform to a professionalised idea of what recovery (and indeed mental illness) involves: what Beresford (2015) calls the colonisation by services of progressive ideas. Roberts and Boardman (2013) report service-user concerns over such colonisation, and highlight a fear that the individual-empowerment aspect of recovery might in fact provide services with an excuse to make cuts in support, something also acknowledged by Bird *et al.* (2014). Rose (2014) expresses concern that recovery discourse has begun to imply conformity to a particular social-normative model.

#### 1.4 Qualitative research and synthesis

Slade *et al.* (2012b) propose that to understand recovery, we have to understand lived experience. From a research perspective, qualitative methodology allows for exactly this: the exploration of individual experience in context (Barker *et al.*, 2002), which may be particularly useful when the focus is on process rather than outcome (Poortman & Schildkamp, 2012). Qualitative synthesis – sometimes called metasynthesis, though this is contested terminology (Dixon-Woods, 2011; Thorne *et al.*, 2004) – allows for the integration and contextual interpretation of existing qualitative studies (Dixon-Woods *et al.*, 2006; Harden, 2010). While the findings of individual qualitative studies are not generalisable to a population (Malterud, 2001), through synthesis we can nevertheless explore and illuminate themes across a corpus of research: something of value to professionals wishing to increase their understanding. A body of work exists examining experiences of recovery from severe and enduring mental illness (SEMI), as considered by Davidson and Roe (2007), but so far the only systematic attempt to synthesise this evidence appears to be Rhodes and De Jager's (2013) review of narrative-inquiry studies (n=4).

Dixon-Woods *et al.* (2005) offer a comprehensive summary of methods of synthesising qualitative evidence, many of which are adaptations of primary analytical techniques and all of which involve some form of ordering, describing and integrating or re-interpreting existing studies. Best-fit framework synthesis has been proposed as a pragmatic, flexible way of achieving this using an a priori framework, such as a published theoretical model which appears broadly applicable to the area under review (Carroll *et al.*, 2013, 2011; Dixon-Woods, 2011). A model can be applied, tested and if necessary refined or redesigned to better integrate the data (Dixon-Woods, 2011). Such an approach is dependent on the existence of an applicable model. As a succinct encapsulation of recovery processes which is

increasingly well validated through its use in research endeavours, CHIME appears promising, and a best-fit framework synthesis using CHIME may be a pragmatic, efficient way of exploring recovery processes.

### 1.4 Objective

The aim of this study was to employ a systematic approach to searching for and analysing published qualitative research in order to answer the question: ‘What do we know about how service users with severe and enduring mental illness experience the process of recovery?’ It also provided an opportunity to further explore the applicability of best-fit framework synthesis (Carroll *et al.*, 2013), and to establish whether the CHIME model (Leamy *et al.*, 2011) provides a workable framework for a qualitative synthesis of recovery processes.

## **2. Method**

Qualitative research is based on an interpretivist epistemology in which the goal is not to establish an objective ‘truth’ but, broadly, to understand and interpret meanings in context (Walsh & Downe, 2006). In keeping with this philosophy, our units of analysis were the results sections of published journal articles, rather than studies: in short, we did not try to divorce data from their interpretation.

### 2.1 Search strategy

The PsycINFO, Medline, Embase and Joanna Briggs Institute electronic databases were first searched to establish that no similar reviews existed, and a Google Scholar search was run. No such reviews were found. The systematic search for articles was limited to those available in English, due to lack of translation facilities. To establish a workable boundary for a time-constrained review, we searched only for articles published in peer-reviewed journals indexed in the four databases named above. It is noted that suboptimal indexing can affect systematic searches, particularly for qualitative studies (Dixon-Woods *et al.*, 2006; Grayson & Gomersall, 2003; Papaioannou *et al.*, 2010). The SPIDER strategy (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) offers a nascent standardised method of searching for qualitative material (Cooke *et al.*, 2012): a modified, over-inclusive version was employed in order to prioritise sensitivity over specificity (Stickley & Wright, 2011). Following pilot searches, the final search string applied to each database was: [("mental health" OR "service use\$") AND ("recovery" AND "disorders" OR "model" OR "approach")] AND "interview\$" OR "experienc\$" OR "qualitative". Databases were

searched in August 2014, from their inception. Searches were re-run in November 2014 to identify whether further eligible articles had been published: none had.

The searches resulted in 2039 records, duplicates excluded. As expected, the large number of records necessitated a lengthy manual screening process, though this was expedited by carefully selected reference-management software (Center for History and New Media, 2014). Figure 1 shows the process by which studies were appraised and selected for quality assessment before the framework-synthesis stage. Twelve of the articles identified in the database search met the inclusion criteria described below. The reference lists of these articles were examined, and three further articles were identified, and subsequently assessed as meeting the inclusion criteria, which had not been found in the electronic searches.

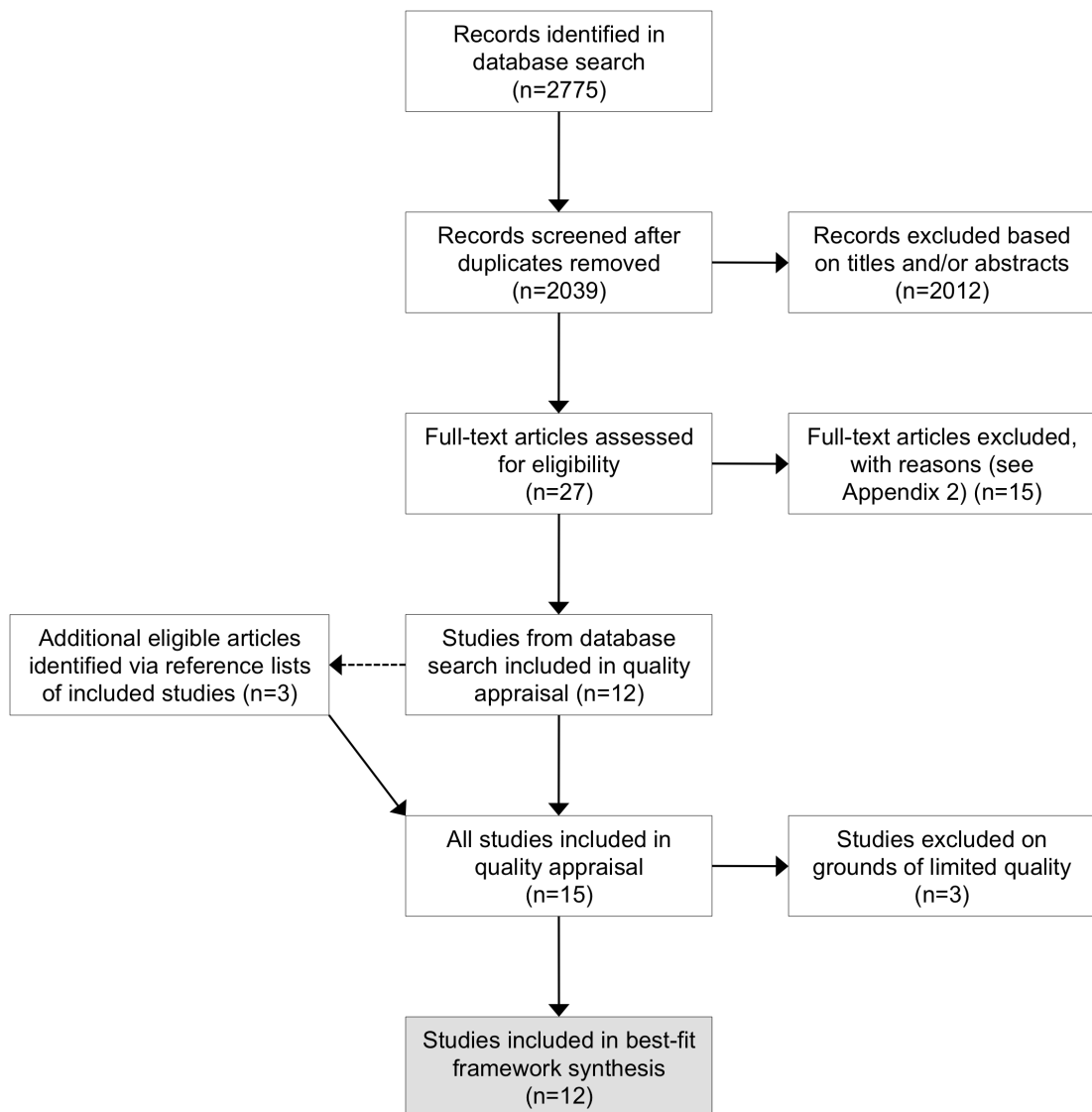


Figure 1: Flowchart showing the process by which studies were appraised and selected.

## 2.2 Inclusion and exclusion criteria

Articles were considered for inclusion if they met the following criteria:

- Provided qualitative analysis of primary-source interview data from adult users (or former users) of mental-health services, who had experienced severe and enduring mental illness, e.g. schizophrenia, bipolar disorder or other psychotic condition, or severe depression, beyond a first episode (Scottish Government, 2005);
- Directly addressed participants' experiences of recovery;
- Situated the concept of recovery within a consumer model, e.g. as broadly defined by Deegan (1988) or Anthony (1993).



Articles were excluded if they were concerned with recovery from first-episode psychosis; with clinical recovery rather than the consumer model; or primarily with the interaction of an external factor (e.g. employment or an intervention) with the recovery process. To maintain homogeneity (Estabrooks *et al.*, 1994), articles were excluded if participants were identified as recovering primarily from a non-SEMI condition (e.g. substance misuse or acquired brain injury), or if they focused on participants delivering services (i.e. peer providers).

### 2.3 Quality assessment

Given that qualitative research is viewed in some circles as inferior to quantitative approaches (Tong *et al.*, 2007), it is perhaps incumbent upon researchers to accentuate issues of quality and methodological rigour. Poor-quality research can distort a synthesis (Dixon-Woods *et al.*, 2004), and while some authors argue that studies should not be excluded based on a priori quality assessment (Carroll *et al.*, 2011), we included only articles that were deemed to be of at least adequate quality (Estabrooks *et al.*, 1994).

Bespoke quality criteria were created, based on the CASP checklist (Critical Appraisal Skills Programme, 2013) but with modifications informed by Campbell *et al.* (2003), Dixon-Woods *et al.* (2007, 2004), Elliott *et al.* (1999) and Yardley (2000). These adaptations enabled an assessment of key issues of design, methodology, analysis, reporting and an article's overall contribution. While there is no infallible method of assessing quality, the use of structured instruments has been found to put a focus on rigour and explicitness from reviewers (Dixon-Woods *et al.*, 2007). An assessment pro-forma was therefore constructed, with a three-level categorical rating system informed by the SIGN 50 guidelines but eschewing ordinal scoring (SIGN, 2014; Walsh & Downe, 2006); see Appendix 3. All articles were rated for quality by the author SRS. Five articles were selected using a simple computerised randomisation process and co-rated by the author EQ. Criteria on which the raters disagreed were discussed and reviewed before the assessment was finalised.

### 2.4 Framework synthesis

Coding of included articles was based on the principles outlined by Carroll *et al.* (2011). Data for synthesis were taken from the Results sections of articles, and consisted of direct quotations by participants, and of the authors' summaries of evidence. The themes proposed in the original articles were set aside, and a line-by-line analysis of the data was conducted, facilitated by NVivo software (QSR, 2014). Discrete units of meaning were identified, as described by Burnard (1994), and were coded according to one of the 26 CHIME categories

(Table 1) if applicable. Each unit of meaning was assigned one code only. Where units of meaning were not adequately captured by CHIME, additional themes were identified and iteratively applied using data-driven thematic analysis (Braun & Clarke, 2006; Carroll *et al.*, 2011; Dixon-Woods *et al.*, 2005). Coding was carried out by SRS. A sample of approximately half the coded data was selected for audit by EQ; the audit supported the thematic structure.

### **3. Results**

#### **3.1 Quality assessment and exclusions**

Table 2 is a comprehensive summary of the 15 papers reviewed in the quality assessment, including a consideration of their strengths and weaknesses. Table 3 shows the quality ratings for each paper. The co-rating of five randomly selected papers showed a concordance of 76% between SRS and EQ, which was deemed acceptable (Stemler, 2004). There were no criteria on which the raters disagreed by more than one category-rating, and there was no disagreement about overall quality.

Three of the 15 papers were rated overall as being of limited quality, and excluded from the subsequent framework synthesis: Smith (2000), Ochocka *et al.* (2005) and Pitt *et al.* (2007). In each, major limitations were a lack of information about how the analysis was conducted, and findings which were not clearly induced from the data (see Tables 2 and 3). This was a particular concern with Ochocka *et al.* (2005): their proposed framework for recovery, involving positive and negative changes, and negotiation between the self and external events, has face validity but is not clearly grounded in the data. Pitt *et al.* (2007) had been of particular interest as a service-user-led paper but, as Tables 2 and 3 show, there were several concerns about quality. If service-user-led research, in this instance co-authored by clinical psychologists, is published in a peer-reviewed journal then it should be subject to the same review procedures.

Table 2: Comprehensive summary of the 15 papers reviewed in the quality assessment.

Authors (year) and country	Primary aim	Participant information	Study design & stated method	Key findings & implications	Strengths	Weaknesses
<b>Young &amp; Ensing (1999), USA</b>	Explore service users' meanings of recovery	<ul style="list-style-type: none"> <li>• N=18 (6♂, 7♀)</li> <li>• Ages 26-59 (M=41)</li> <li>• 5 African American, 13 European Am.</li> <li>• Various diagnoses</li> <li>• Recruited via local organisations</li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured individual interviews (n=7) and two focus groups (n=5 &amp; n=6)</li> <li>• Grounded Theory</li> </ul>	<ul style="list-style-type: none"> <li>• Five categories over three phases: 1. Overcoming stuckness; 2a. Fostering self-empowerment; 2b. Learning and self-redefinition; 2c. Returning to basic functioning; 3. Improving QoL</li> </ul>	<ul style="list-style-type: none"> <li>• Wide range of quotes (though individual voices not differentiated)</li> <li>• Elucidation of themes such as basic functioning and spirituality</li> </ul>	<ul style="list-style-type: none"> <li>• Analysis does not follow GT principles</li> <li>• Possible normative effect of focus groups</li> <li>• Some analysis by uncredited junior researchers</li> <li>• Limitations not acknowledged</li> </ul>
<b>Smith (2000), USA</b>	Establish common elements among recovery stories, to inform services	<ul style="list-style-type: none"> <li>• N=10 (5♂, 5♀)</li> <li>• Ages 38-60 (M=48)</li> <li>• 1 African American, 9 Caucasian</li> <li>• 9 college educated</li> <li>• Various diagnoses</li> <li>• Recruited via consumer newsletter</li> <li>• Paid participants</li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured individual interviews</li> <li>• Method unclear: no approach named or described</li> </ul>	<ul style="list-style-type: none"> <li>• Five major themes: 1. Meaning of recovery; 2. Turning points; 3. Critical factors; 4. Barriers; 5. Strategies</li> </ul>	<ul style="list-style-type: none"> <li>• Interesting quotes support the themes (though voices not differentiated)</li> </ul>	<ul style="list-style-type: none"> <li>• Highly educated sample does not match aim of finding 'common elements', and findings are over-generalised</li> <li>• Unclear method</li> <li>• Limitations not acknowledged</li> </ul>

Table continues on next page

Table 2: Comprehensive summary of the 15 papers reviewed in the quality assessment.

Authors	Primary aim	Participants	Stated design	Key findings	Strengths	Weaknesses
<b>Spaniol (2002), USA</b>	Describe the process of recovery, and its key dimensions and factors	<ul style="list-style-type: none"> <li>• N=12 (6♂, 6♀)</li> <li>• Ages 30-53 (M=41)</li> <li>• 7 African American, 1 south-east Asian, 4 Caucasian</li> <li>• Randomly selected from vocational study</li> <li>• Met DSM-III-R schizophrenia criteria</li> <li>• Educational diversity</li> <li>• Paid participants</li> </ul>	<ul style="list-style-type: none"> <li>• Series of open-ended interviews over four years</li> <li>• Non-specific method of inductive analysis; also refers to thematic analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Four-phase model: 1. Overwhelmed by the disability; 2. Struggling with the disability; 3. Living with the disability; 4. Living beyond the disability</li> </ul>	<ul style="list-style-type: none"> <li>• Input into design from people with lived experience</li> <li>• Phased model has face validity and is considered in social and clinical context</li> <li>• Consideration of themes including race &amp; disadvantage</li> </ul>	<ul style="list-style-type: none"> <li>• Data-collection method unclear and analysis very unclear</li> <li>• As a longitudinal study there is maybe an imbalance between detailed and broad information</li> </ul>
<b>Tooth <i>et al.</i> (2003), Australia</b>	Identify what service users consider important, compare with the literature & provide a definition	<ul style="list-style-type: none"> <li>• N=60 (44♂, 16♀)</li> <li>• Ages 21-60 (M=36)</li> <li>• Met DSM-IV criteria for schizophrenia</li> <li>• Educational diversity</li> <li>• 58% unemployed</li> <li>• Recruited via adverts and services</li> </ul>	<ul style="list-style-type: none"> <li>• Four-part interview including open-ended and semi-structured elements</li> <li>• Thematic analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Frequency analysis suggests most common thematic category relates to active sense of self</li> <li>• Key subthemes included determination to get better, and recognising need for responsibility</li> </ul>	<ul style="list-style-type: none"> <li>• Input into design from service users</li> <li>• Frequency analysis is clearly tabulated and is based on large N for qual. study</li> </ul>	<ul style="list-style-type: none"> <li>• Predicated on odd idea that qualitative enquiry should be free of interpretation</li> <li>• Very short Results; few supporting quotes</li> <li>• Limitations not acknowledged</li> </ul>

Table continues on next page

Table 2: Comprehensive summary of the 15 papers reviewed in the quality assessment.

Authors	Primary aim	Participants	Stated design	Key findings	Strengths	Weaknesses
<b>Thornhill <i>et al.</i> (2004), UK</b>	Explore genre, tone and narrative in accounts of people self-identifying as in recovery from psychosis	<ul style="list-style-type: none"> <li>• N=15 (6♂, 9♀)</li> <li>• Ages 30-70</li> <li>• Various diagnoses</li> <li>• 'Most' white European; two Asian</li> <li>• Recruited through advertisements and word-of-mouth</li> <li>• Mostly 'educated'</li> </ul>	<ul style="list-style-type: none"> <li>• Face-to-face interview</li> <li>• Narrative analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Three narrative genres: 1. Escape; 2. Enlightenment; 3. Endurance</li> <li>• Various tones identified, including protesting, resigned and disenfranchised</li> </ul>	<ul style="list-style-type: none"> <li>• Rigorous, coherent analytical approach</li> <li>• Attention to context and issues of power: participants asked to comment on analysis</li> <li>• Consideration of related clinical issues</li> </ul>	<ul style="list-style-type: none"> <li>• Four participants are not quoted, raising concerns about transparency</li> <li>• Discussion of limitations is very brief</li> <li>• No mention of ethical issues</li> </ul>
<b>Davidson <i>et al.</i> (2005), Italy, Norway, Sweden, USA</b>	<ul style="list-style-type: none"> <li>• Delineate processes of recovery described by people with psychosis</li> <li>• Part of a multinational, multi-article study</li> </ul>	<ul style="list-style-type: none"> <li>• N=12 (5♂, 7♀)</li> <li>• Ages 29-55</li> <li>• Various diagnoses</li> <li>• None married</li> <li>• Range of current employment</li> </ul>	<ul style="list-style-type: none"> <li>• Open-ended interviews</li> <li>• Non-English interviews translated into English</li> <li>• 'Established qualitative procedures'</li> </ul>	<ul style="list-style-type: none"> <li>• Five salient themes: 1. How the person deals with their problems; 2. Material resources; 3. Health systems; 4. Significant others; 5. Social and cultural factors</li> </ul>	<ul style="list-style-type: none"> <li>• Ambitious international study</li> <li>• Substantial use of participant quotes</li> </ul>	<ul style="list-style-type: none"> <li>• Bespoke qualitative method is weakly evidenced</li> <li>• Does not seek to integrate with existing recovery literature</li> <li>• Limitations not acknowledged</li> </ul>

Table continues on next page

Table 2: Comprehensive summary of the 15 papers reviewed in the quality assessment.

Authors	Primary aim	Participants	Stated design	Key findings	Strengths	Weaknesses
<b>Marin <i>et al.</i> (2005), Italy, Norway, Sweden, USA</b>	As above, but focusing on people's role in their own recovery	<ul style="list-style-type: none"> <li>• As Davidson <i>et al.</i> (2005), above</li> </ul>	<ul style="list-style-type: none"> <li>• As Davidson <i>et al.</i> (2005), above</li> </ul>	<ul style="list-style-type: none"> <li>• Three super-ordinate themes: 1. Determination to succeed; 2. Self control; 3. New identity</li> <li>• Salient subthemes included symptom management, and social demands</li> </ul>	<ul style="list-style-type: none"> <li>• Clear, thoughtful analysis of findings in context of the aim posed by Davidson <i>et al.</i> (2005)</li> <li>• Participants clearly individuated</li> <li>• Summary offers pertinent points for clinicians</li> </ul>	<ul style="list-style-type: none"> <li>• As above, method of analysis is opaque</li> <li>• Again, findings are not presented in the context of existing literature, and limitations are not acknowledged</li> </ul>
<b>Ochocka <i>et al.</i> (2005), Canada</b>	Clarify the concept of recovery as experienced by people with SEMI	<ul style="list-style-type: none"> <li>• N=28</li> <li>• 12 active in consumer/survivor initiatives</li> <li>• No other information provided</li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured interviews at three time points</li> <li>• 'A grounded theory analysis'</li> </ul>	<ul style="list-style-type: none"> <li>• Multidimensional model with four main components: 1. Drive to move forward; 2. Spiral of life struggle; 3. Context of self and circumstances; 4. Negotiation between self &amp; external factors</li> </ul>	<ul style="list-style-type: none"> <li>• Service users involved in development, data gathering &amp; analysis</li> <li>• Proposed model has face validity; suggested interaction with health/social systems is well argued</li> </ul>	<ul style="list-style-type: none"> <li>• Sample unclear</li> <li>• Analysis unclear</li> <li>• Difficult to ascertain to what extent data contributes to the proposed model</li> <li>• Limitations not acknowledged</li> </ul>

Table continues on next page

Table 2: Comprehensive summary of the 15 papers reviewed in the quality assessment.

Authors	Primary aim	Participants	Stated design	Key findings	Strengths	Weaknesses
<b>Jensen &amp; Wadkins (2007), USA</b>	<ul style="list-style-type: none"> <li>Find out what it means to live successfully with SEMI and what contributes to recovery</li> <li>In context of evaluating a community initiative, on which funding may have been contingent</li> </ul>	<ul style="list-style-type: none"> <li>N=20 (9♂, 11♀)</li> <li>Ages 19-64</li> <li>14 from urban areas, six rural</li> <li>Purposive sampling via community-based initiative</li> <li>Various diagnoses</li> <li>Paid \$10 stipend</li> </ul>	<ul style="list-style-type: none"> <li>Semi-structured interviews</li> <li>'Editing analysis style'</li> </ul>	Four common master themes: 1. Finding acceptance and understanding of illness; 2. Redefining identity & preventing relapse; 3. Finding a way to advocate and help others; 4. Barriers in the paths to recovery	<ul style="list-style-type: none"> <li>Clearly described, contextually aware research</li> <li>Findings situated within wider context of recovery &amp; care</li> <li>Interesting points made, based on the data, about the value of integrating formal and informal services</li> </ul>	<ul style="list-style-type: none"> <li>Individual voices are not differentiated, so contributions to each theme are not entirely clear</li> <li>Analysis based on simple themes: a more interpretative approach may have been of benefit</li> </ul>
<b>Pitt <i>et al.</i> (2007), UK</b>	Carry out service-user-led research into recovery, exploring experiences and defining recovery	<ul style="list-style-type: none"> <li>N=7 (5♂, 2♀)</li> <li>Ages 18-65</li> <li>6 white, one mixed-race</li> <li>Recruited through mental-health groups</li> <li>Personal experience of psychosis</li> </ul>	<ul style="list-style-type: none"> <li>Semi-structured interviews</li> <li>Method is stated to be interpretative phenomenological analysis</li> </ul>	<ul style="list-style-type: none"> <li>Seven definitions of recovery, plus three superordinate themes:</li> <li>1. Rebuilding of self</li> <li>2. Rebuilding of life</li> <li>3. Hope for a better future</li> </ul>	<ul style="list-style-type: none"> <li>Service-user-led project: first two authors, who conducted the study, were user-researchers</li> </ul>	<ul style="list-style-type: none"> <li>Actual method seems incongruent with IPA: themes appear to be decided by a committee</li> <li>Evidence from less than 50% of sample is presented</li> <li>Findings are discussed in terms of generalisability: not in keeping with IPA</li> </ul>

Table continues on next page

Table 2: Comprehensive summary of the 15 papers reviewed in the quality assessment.

Authors	Primary aim	Participants	Stated design	Key findings	Strengths	Weaknesses
<b>Borg &amp; Davidson (2008), Norway</b>	Explore how individuals with SEMI experience their illness, and how they find a sense of meaning & purpose	<ul style="list-style-type: none"> <li>• N=13 (6♂, 7♀)</li> <li>• Ages 26-54</li> <li>• Two married, two engaged, two with children</li> <li>• Six higher educated</li> <li>• Various diagnoses and social situations</li> </ul>	<ul style="list-style-type: none"> <li>• Open-ended interviews, twice over one year</li> <li>• Narrative phenomenological approach, described as thematic and step-wise</li> </ul>	<ul style="list-style-type: none"> <li>• Four major themes:               <ol style="list-style-type: none"> <li>1. Being normal</li> <li>2. Just doing it</li> <li>3. Making life easier</li> <li>4. Being good to yourself</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• People with lived experience had input into the design and were consulted during analysis</li> <li>• Detailed, interpretative analysis of experience is offered</li> </ul>	<ul style="list-style-type: none"> <li>• Two participants did not wish to be audiotaped: analysis of these interviews is based on written notes</li> <li>• Limitations not acknowledged</li> <li>• Findings possibly overstated based on the data presented</li> </ul>
<b>Armour <i>et al.</i> (2009), USA</b>	Understand the lived experience of recovery for African Americans with SEMI	<ul style="list-style-type: none"> <li>• N=9 (4♂, 5♀)</li> <li>• Ages 25-54 (M=36)</li> <li>• Various diagnoses</li> <li>• Part of sample recruited from a community programme</li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured interviews at three time points</li> <li>• Hermeneutic phenomenological method</li> </ul>	<ul style="list-style-type: none"> <li>• Four major themes:               <ol style="list-style-type: none"> <li>1. Striving for normalcy; 2. Striving to stay 'up'; 3. Coping with consequences of illness; 4. Leaning on support from others</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Culturally aware study with extensive contextual validation</li> <li>• Consideration of social &amp; care context</li> <li>• Suggestions made for future research</li> </ul>	<ul style="list-style-type: none"> <li>• Individual voices are not differentiated</li> <li>• Some themes and interpretations appear more descriptive than phenomenological</li> </ul>

Table continues on next page



Table 2: Comprehensive summary of the 15 papers reviewed in the quality assessment.

Authors	Primary aim	Participants	Stated design	Key findings	Strengths	Weaknesses
<b>Piat <i>et al.</i> (2009), Canada</b>	<ul style="list-style-type: none"> <li>• Determine the understanding of recovery among a sample of service users in Canada</li> <li>• Part of wider study exploring meaning of recovery for service users, providers and planners</li> </ul>	<ul style="list-style-type: none"> <li>• N=54 (26♂, 28♀)</li> <li>• Mean age 43.6</li> <li>• 47% had post-secondary education</li> <li>• 45% in work</li> <li>• Various diagnoses</li> <li>• Recruitment by self-referral following awareness-raising</li> <li>• Small honorarium</li> </ul>	<ul style="list-style-type: none"> <li>• Semi-structured interviews over a two-year period</li> <li>• 'No pre-set theoretical framework influenced data analysis' (p.201)</li> </ul>	<ul style="list-style-type: none"> <li>• Two meanings with three themes each:               <ol style="list-style-type: none"> <li>1. Recovery in relation to illness:                   <ol style="list-style-type: none"> <li>i. Cure; ii. Medication; iii. Returning to former self;</li> </ol> </li> <li>2. Recovery in relation to wellness:                   <ol style="list-style-type: none"> <li>i. Taking charge of life; ii. Process; iii. A new self</li> </ol> </li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Research overseen by an advisory committee including service users</li> <li>• Very large sample for a qualitative study: a significant research undertaking</li> </ul>	<ul style="list-style-type: none"> <li>• Seems to have been conducted in both English and French: however, no related interpretative issues are considered</li> <li>• Lack of any analytical framework reduces transparency</li> </ul>
<b>Mezey <i>et al.</i> (2010), UK</b>	<ul style="list-style-type: none"> <li>• Explore forensic inpatient perceptions of recovery &amp; identify whether these were different from others'</li> <li>• Extension of study including people with eating disorders and substance issues (Turton <i>et al.</i>, 2011)</li> </ul>	<ul style="list-style-type: none"> <li>• N=10 (8♂, 2♀)</li> <li>• Ages 24-56 (M=37)</li> <li>• Four white</li> <li>• Diagnoses of schizophrenia or schizoaffective disorder</li> <li>• Recruited from one medium-secure unit</li> <li>• Paid £20</li> </ul>	<ul style="list-style-type: none"> <li>• Face-to-face interviews in two parts: open-ended, then semi-structured</li> <li>• Preliminary thematic analysis using grounded theory coding tools; then directed content analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Three key areas:               <ol style="list-style-type: none"> <li>1. Definitions and understandings of recovery;</li> <li>2. What helps to bring about recovery;</li> <li>3. Impediments to recovery</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>• Only study to include voices of forensic patients</li> <li>• Analysis &amp; discussion raise points about relevance of recovery model to different populations</li> </ul>	<ul style="list-style-type: none"> <li>• Directed-content-analysis element is not clear, reducing transparency</li> <li>• Despite aim, findings are not contrasted with other literature</li> <li>• Individual voices not differentiated</li> </ul>

Table continues on next page

Table 2: Comprehensive summary of the 15 papers reviewed in the quality assessment.

Authors	Primary aim	Participants	Stated design	Key findings	Strengths	Weaknesses
<b>Veseth <i>et al.</i> (2012), Norway</b>	Explore lived experiences of improvement in bipolar disorder, including what people do to promote their own recovery	<ul style="list-style-type: none"> <li>• N=13 (6♂, 7♀)</li> <li>• Ages 27-65 (M=47)</li> <li>• Diagnoses of bipolar I &amp; II, plus comorbidities</li> <li>• Six employed</li> <li>• Various relationship statuses</li> <li>• Recruitment via newspaper advert (n=3) and outpatient clinic (n=10)</li> <li>• Paid participants</li> </ul>	<ul style="list-style-type: none"> <li>• Open-ended interviews</li> <li>• Hermeneutic-phenomenological approach</li> </ul>	<ul style="list-style-type: none"> <li>• Four major themes: 1. Handling ambivalence about letting go of manic states; 2. Finding something to hang on to; 3. Becoming aware of signals from self and others; 4. Finding ways of caring for oneself</li> </ul>	<ul style="list-style-type: none"> <li>• 12 service-user co-researchers very involved in designing and running study</li> <li>• Reflexively aware collaborative analysis with 'bias ... as an important focus' (p.130)</li> <li>• Detailed extracts</li> </ul>	<ul style="list-style-type: none"> <li>• Method of analysis is complex. Use of a more obvious model (e.g. IPA) may have increased transparency</li> <li>• Individual voices are not differentiated: unusual for such a person-focused study</li> </ul>

Table 3: Quality ratings for the 15 papers. (The criteria are detailed fully in Appendix 3.)

Study	Quality criteria										
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	Overall
	Research questions clear	Research questions suited to qual.	Participants and recruitment	Context and reflexivity	Ethical issues	Method of data collection	Method of data analysis	Analysis and interpretations of data	Statement and discussion of findings	Usefulness of contribution	Overall rating based on mode of the 10 criteria
Young & Ensing (1999)	++	+	+	-	-	+	-	+	-	+	+
Smith (2000)*	+	+	-	-	-	+	-	-	-	-	-
Spaniol (2002)	++	+	+	-	-	+	-	-	++	+	+
Tooth <i>et al.</i> (2003)	+	+	+	+	+	+	+	+	-	+	+
Thornhill <i>et al.</i> (2004)	++	++	+	++	-	+	++	+	+	++	++
Davidson <i>et al.</i> (2005)	+	+	+	-	-	+	-	+	-	+	+
Marin <i>et al.</i> (2005)	+	+	+	-	-	+	-	+	-	+	+
Ochocka <i>et al.</i> (2005)*	+	-	-	++	-	+	-	-	-	+	-
Jensen & Wadkins (2007)	++	+	+	+	++	+	+	+	+	++	+
Pitt <i>et al.</i> (2007)*	++	+	+	+	-	+	-	-	-	-	-
Borg & Davidson (2008)	++	+	-	+	+	+	+	+	-	+	+
Armour <i>et al.</i> (2009)	++	++	+	++	-	+	++	+	+	++	++
Piat <i>et al.</i> (2009)	++	-	+	+	++	+	-	++	+	+	+
Mezey <i>et al.</i> (2010)	++	+	+	+	++	+	+	+	+	++	+
Veseth <i>et al.</i> (2012)	++	+	+	++	++	+	++	+	++	++	++

\* Excluded from framework analysis after quality assessment.

### 3.2 Quality of papers included in framework synthesis

Based on the modal rating of the 10 systematically applied quality criteria, 12 papers were rated as being of acceptable quality for inclusion in the synthesis (Table 3). Three were noteworthy overall: Thornhill *et al.* (2004), Armour *et al.* (2009) and Veseth *et al.* (2012). Spaniol *et al.* (2002) had an equal number of categories rated as limited and acceptable, but was rated very highly for clarity of research question, and statement and discussion of findings, and hence was included. The 12 papers accounted for a total N of 236 participants from primarily community settings: see Table 1 for demographic details. Not all participant voices were reported: indeed, even in the highly rated Thornhill *et al.* (2004), some participants were not quoted. It was also noted that in certain papers – including the noteworthy Armour *et al.* (2009) and Veseth *et al.* (2012) – individual participants' voices were not differentiated, reducing transparency. However, findings were at least adequately supported by data in all 12 papers.

As shown in Table 2, various methods of qualitative analysis were used. In some cases (e.g. Piat *et al.*, 2009) a method was not specified but analysis was nevertheless clearly described and appeared rigorous. It is perhaps notable that the three papers which scored most highly on method were also deemed strongest overall (Table 3). Two of these (Armour *et al.*, 2009, and Veseth *et al.*, 2012) detailed a hermeneutic-phenomenological approach similar to, but not identified as, IPA. Table 3 also shows that the addressing of context and reflexivity improved over time, perhaps as qualitative approaches have become more methodically formalised (Dixon-Woods *et al.*, 2007). Ethical issues were poorly reported by the majority of papers but, again, there was a trend towards improvement over time. With the exception of Pitt *et al.* (2007), articles from 2007 and later tended to perform better on all criteria than did earlier papers. The four post-2009 papers also contained reflections on their limitations: the omission of such reflection was a notable flaw with many earlier papers, and adversely affected ratings of statement and discussion of findings.

It was felt that each of the 12 included articles made a useful contribution to the overall knowledge base about recovery: a strongly subjective judgement, but one which Dixon-Woods *et al.* (2004) exhort researchers to consider. The same could be said of Ochocka *et al.* (2005), which at least offers an imaginative hypothesis of the recovery process. However, the exclusion of that paper highlights the importance of robust quality criteria in order to ensure that the results of a qualitative synthesis are transparently data-driven.

### 3.3 Framework synthesis

Results sections of each paper were coded line-by-line. Where units of meaning were not captured by one of the CHIME subthemes and master themes (Table 1), the data were thematically analysed and new themes were induced (Braun & Clarke, 2006). These are displayed in Table 4. Three of these newly identified themes were mapped back on to the CHIME master themes of Hope and Empowerment. The remaining 12 were organised into four new master themes: Acceptance and Mindful Awareness, Difficulties, Returning to or Desiring Normality, and Therapeutic Input.

Table 4: Additional themes and the master themes into which they were subsumed.

Additional theme identified during initial coding	Refined into master theme
Escape from something undesirable	<b>Hope (CHIME theme)</b>
Exercise and maintaining good physical health	<b>Empowerment (CHIME theme)</b>
Self-compassion	
Acceptance	<b>Acceptance and mindful awareness (new theme)</b>
Grounding in present moment	
Ambivalence and contradiction	<b>Difficulties (new theme)</b>
Disempowerment	
Financial concerns	
Loss and negative life changes	
Stumbling, struggling and suffering	
Substance use comorbid with mental illness	
Return to or desire for normality, including symptom reduction	<b>Returning to or desiring normality (new theme)</b>
Having the basics	
Benefiting from specific therapeutic or professional input	<b>Therapeutic input (new theme)</b>
Having concern about specific therapeutic or professional input, including medication side-effects	

In total, then, the best-fit framework synthesis resulted in nine master themes: five from CHIME, plus four newly identified. The CHIME master themes accounted for 68% of the data. Table 5 displays the nine themes in order of coding density. Given that coding was a subjective process by one researcher, quantification is disputable; the colour-shading of the table is therefore intended to give a broad impression of coding density. Shading was applied with a 5% leeway for error.

Table 5: The nine master themes in order of coding density.

Master theme	Percentage of data accounted for by theme
<b>Empowerment *</b>	18.4%
<b>Difficulties **</b>	14.8%
<b>Hope and optimism about future *</b>	14.6%
<b>Meaning in life *</b>	14.1%
<b>Connectedness *</b>	13.7%
<b>Identity *</b>	7.6%
<b>Therapeutic input **</b>	6.9%
<b>Acceptance and mindful awareness **</b>	5.2%
<b>Returning to, or desiring, normality **</b>	4.7%

\* CHIME master theme    \*\* New master theme

Key to colour coding
> 251 units of meaning
201-250 units of meaning
151-200 units of meaning
101-150 units of meaning
< 101 units of meaning

Table 6 shows the percentage of each individual paper accounted for by each of the nine master themes.

### 3.3.1 The CHIME master themes

The curious reader is directed to Leamy *et al.* (2011) for a more comprehensive description of these themes and their subthemes.

#### Empowerment

Table 5 shows that Empowerment was the predominantly coded theme in this review, at 18.4% of the total data. Table 6 shows that it accounted for more than 20% of the data in one-third of the papers reviewed, and more than 30% of that in Marin *et al.* (2005). The only study in which Empowerment accounted for less than 10% of coding was Mezey *et al.* (2010), perhaps explained by the interviewees being disempowered in a secure psychiatric unit. Subthemes of Empowerment within CHIME are personal responsibility, control over life and focus on strengths, to which this analysis added self-compassion, and exercise and maintaining good physical health. Two examples from the data underscore the general conceptualisation of Empowerment: the participant Susanne, in Borg and Davidson (2008), who likens recovery to the sportswear slogan “Just Do It”; and Jan, in Marin *et al.* (2005), who states that his recovery began with the small but vital decision to get out of bed. Much of the data within this theme support the suggestion that recovery is something which is ultimately up to the individual to pursue (Davidson & Roe, 2007).

Table 6: Percentages of each paper accounted for by each of the nine master themes.

	<b>Percentage of each paper's Results section accounted for by each code</b>								
	<b>C</b>	<b>H</b>	<b>I</b>	<b>M</b>	<b>E</b>	<b>Acc.</b>	<b>Diff.</b>	<b>Norm.</b>	<b>Ther.</b>
	Connected-ness	Hope & optimism re: future	Identity	Meaning in life	Empowerment	Acceptance & mindful awareness	Difficulties	Return to or desire for normality	Therapeutic input
Young & Ensing (1999)	9.8	16.5	13.4	16.5	21.6	5.7	7.7	5.7	3.1
Spaniol <i>et al.</i> (2002)	10.3	8.6	4.3	9.5	11.2	5.2	40.5	3.4	6.9
Tooth <i>et al.</i> (2003)	13.3	8.3	5.0	6.7	20.0	6.7	11.7	6.7	21.7
Thornhill <i>et al.</i> (2004)	12.0	13.3	8.0	21.3	10.7	8.0	12.0	2.7	12.0
Davidson <i>et al.</i> (2005)	19.6	10.6	9.0	15.3	16.9	6.9	12.2	2.6	6.9
Marin <i>et al.</i> (2005)	7.4	19.0	6.9	12.5	30.6	5.1	12.0	4.2	2.3
Jensen & Wadkins (2007)	23.7	4.1	10.3	21.6	13.4	3.1	7.2	0.0	16.5
Borg & Davidson (2008)	20.2	9.2	3.7	24.8	15.6	1.8	6.4	11.0	7.3
Armour <i>et al.</i> (2009)	22.2	29.6	0.7	8.1	13.3	4.4	14.8	3.7	3.0
Piat <i>et al.</i> (2009)	2.1	19.6	11.9	11.9	18.9	7.7	14.7	8.4	4.9
Mezey <i>et al.</i> (2010)	15.7	15.7	9.0	7.9	4.5	0.0	23.6	6.7	16.9
Veseth <i>et al.</i> (2012)	16.1	6.9	3.4	12.6	29.9	6.9	23.0	1.1	0.0
<b>Colour key</b>	0-5% of paper		5.1-10% of paper		10.1-15% of paper		15.1-20% of paper		> 20% of paper

### Hope and optimism about the future

This theme accounted for 14.6% of all data (Table 5). Participants talked of their hopes of better health, prosperity and relationships, and their beliefs that these were possible. Carol, in Davidson *et al.* (2005), described optimism that there would be an end to struggle:

*'Hope of knowing that everything that is, that I go through, would not continue the rest of my life, that there would be an end of it; and just knowing that I knew that, I could keep going'* (p.184).

Table 6 shows that this theme was particularly strong in Armour *et al.* (2009), accounting for almost 30% of the data. It is possible that the African-American participants in this study were more socially disadvantaged than other interviewees, and therefore put more emphasis on hope for change: however, Armour *et al.* (2009) also query whether the level of optimism might be related to efforts to seem credible to a white interviewer. The theme appears disproportionately low in Jensen & Wadkins (2007): while this may be related to the non-interpretative approach adopted by those authors (Table 2), dynamic interplay between the CHIME themes might also render them difficult to delineate (Slade *et al.*, 2012b). In the present review, the master themes of Hope, Meaning and Connectedness accounted for similar proportions of coded data, and differentiation may sometimes be arbitrary. For example, within the subthemes, motivation to change is an aspect of Hope, but interplay – or perhaps overlap – can be seen between this and the subthemes of control and responsibility within Empowerment. The following quote from Armour *et al.* (2009), coded at the present theme, illustrates this:

*'The more I do it (life), the better I get at it. You know, practice, practice, practice. Life is like that.'* (p.610)

The original CHIME subthemes within Hope are broadly appetitive, suggesting movement towards a desired goal (Table 1). The newly identified subtheme of escape is aversive, but fits within a general theme of positively believing that one's life could be better. For example, Piat *et al.* (2009) report that 'several [participants] advocated forgetting the past and its negative connotations' (p.204).

### Meaning in life

This accounted for 14.1% of data, and was the most heavily coded theme in Thornhill *et al.* (2004) and Borg and Davidson (2008) (Table 6). It included the sense of meaning that comes from involvement with social groups and rewarding activities, including employment; and the meaning that can arise from a positive evaluation of the experience of mental illness



itself. This latter process involved not just a realisation that psychosis might be rooted in previous aversive experiences – a recurring theme in Thornhill *et al.* (2004) – but a reconsideration of one's place in society:

*'I think it has to do with my learning to be a better person ... that I have to learn to appreciate those who are sick, those who have a hard time'* (Marin *et al.*, 2005, p.240).

Several participants described finding meaning in helping others: for example the interviewee in Armour *et al.* (2009) who talked of teaching someone music, and the participants in Jensen and Wadkins (2007) who talked proudly of their advocacy work. Marin *et al.* (2005) describe how two participants found new meaning in life after taking increased responsibility for their physical wellbeing. As in the theme of Empowerment, examples such as this reinforce the impression that recovery is something an individual actively pursues for themselves.

### Connectedness

Table 5 shows that 13.7% of data was coded at this theme: a similar density to the previous two themes. It was the most densely coded theme in Jensen and Wadkins (2007) (Table 6). Broadly, this category indicates that empowerment does not always have to be self-empowerment, and that recovery is rarely a solo journey:

*'If I come here and see that there are others who have the same kind of life as me – well, we can help each other, give and take. That's how human relationships work'* (Davidson *et al.*, 2005, p190).

Forensic inpatients interviewed by Mezey *et al.* (2010) talked of feeling valued by others:

*'When I was unwell I never had any kind of, any support from anyone, I was totally alone ... now I'm here it is important to have recognition and support by people because it helps'* (Mezey *et al.*, 2010, p.690).

Non-human contact was important: pets are discussed by participants in Armour *et al.* (2009), Borg and Davidson (2008) and Davidson *et al.* (2005). Participants in Jensen and Wadkins (2007) talked of the connections they felt from the advocacy work coded at Meaning, above: another example of the overlapping of themes. Jensen and Wadkins (2007) refer explicitly to the importance within recovery of helping other people.

### Identity

At 7.6% of all data (Table 5) and no more than 13.4% of any individual paper (Table 6), Identity accounted for substantially less of the coding than the other CHIME themes. This is possibly because of further overlap. For instance, one man quoted in Armour *et al.* (2009) talks about sticking with a job (social role; personal responsibility) in order to feel like a person again (reclaiming identity): it is debatable as to which aspect is most salient. Davidson and Strauss (1992), in an interview-based study of selfhood among people with SEMI, note that recovery is likely to involve the reconstruction of selfhood through activity and agency, suggesting that identity change might be a secondary recovery process. Nevertheless, the theme sheds further light on what it means to be in recovery. For example, participants talk of being validated as an individual with something to offer the world (Davidson *et al.*, 2005); of feeling a return to their former selves (Piat *et al.*, 2009); and of overcoming stigma:

*'It wasn't until I started learning about my rights that I started searching for the ability to be treated as an individual'* (Jensen & Wadkins, 2007, p.332).

### 3.3.2 Additional master themes

These were developed via thematic analysis (Braun & Clarke, 2006; Carroll *et al.*, 2013, 2011) to account for data not coded at any of the CHIME themes.

### Difficulties

This was the second most frequent master theme to emerge, at 14.8% of all data: more than any CHIME theme other than Empowerment (Table 5). As Table 6 shows, it accounts for no less than 6% of each paper: in three cases it accounts for more than 20%, and in one (Spaniol *et al.*, 2002) for 40.5%, the most of any theme in any paper. The Spaniol *et al.* (2002) study, in which two of the four primary themes proposed by the authors were overwhelmingly negative (Table 2), was a longitudinal design with research input from people with experience of severe mental illness, suggesting ecological validity.

Participants in all papers described dealing with an array of struggles and concerns as part of the recovery process, including the intrapsychic, the interpersonal and the financial (Table 4). Some appeared ambivalent about recovery: Spaniol *et al.* (2002) underline how empowerment leads to the withdrawal of social support, creating new difficulties. Others were blunt: one participant in Mezey *et al.* (2010), asked about the importance of hope in recovery, replied: 'Hope will get you nowhere I don't think' (p.688). Piat *et al.* (2009)

describe participants feeling like they were moving backwards in their recovery, and quote one, Janet, as saying: ‘I don’t just take one step, two steps back, I take five or six’ (p.204).

Davidson *et al.* (2005) note that the process of recovery is made more difficult by the deleterious effects of long-term psychotic illness upon cognitive ability: a challenge to the dominant theme of empowerment. The CHIME model may, then, be predicated on an overly optimistic view of recovery, and while focusing on the positives might enable services to foster hope (Stickley & Wright, 2011), it risks minimising a large part of the process.

### Therapeutic input

This theme, which accounted for just less than 7% of total data (Table 5), could arguably have been subsumed into Connectedness. However, it was identified as a process in 11 of the 12 papers, and more than 20% of the data in Tooth *et al.* (2003) was coded at this theme (Table 6), suggesting it is usefully considered on its own. Concerns around therapeutic input, including problems with medication, talking therapy and general staff attitudes, were identified in eight of the 12 papers, pointing to practical considerations for services. Some participants placed great value on medication, a theme not adequately captured elsewhere.

### Acceptance and mindful awareness

Identified in 11 papers, but never at more than 8% (Table 6), this theme accounted for just over 5% of total data (Table 5). Those participants who endorsed it spoke of accepting limitations, having patience, and learning to focus their attention on the present, not the past or future. This is a complex concept but one which is increasingly a therapeutic focus (Hayes *et al.*, 2013) and may offer scope for practitioners hoping to improve recovery outcomes.

### Returning to, or desiring, normality

Less than 5% of total data were coded at this theme (Table 5), though it captured 11% in Borg & Davidson (2008). While it could be linked to the CHIME theme of Hope, it was sometimes expressed without optimism: for example, Marin *et al.* (2005) note that, for their participants, trying to live a normal life can involve ‘finding the strength to “fight twice as hard”’ (p.237). Davidson *et al.* (2005) describe participants’ ‘need for material resources and a sense of home’ (p.183). While there are echoes of the subtheme of rebuilding life within the CHIME theme of Meaning, this is about basic survival, not finding meaning. It is also notable that themes of normalcy were prominent in two of the primary analyses (Armour *et al.*, 2009, and Borg & Davidson, 2008), adding credence to this as a master theme.

## 4. Discussion

### 4.1 The master themes

This systematic review used best-fit framework synthesis as a way of answering the question: ‘What do we know about how service users with severe and enduring mental illness experience the process of recovery?’ The framework chosen was the CHIME model proposed by Leamy *et al.* (2011). The results suggest that while the five CHIME processes encapsulate the majority of people’s recovery experiences, they are not sufficient. Four further master themes were induced from the data: these plus CHIME allowed for a comprehensive consideration of recovery processes as described by up to 236 participants in the 12 papers reviewed. This points to further expansion of the CHIME model, perhaps also incorporating dynamic interplay both within and between themes. The construction of a dynamic model would be a significant task, beyond the constraints of this review. However, we believe that the present work provides an important step to further exploration.

Of particular note is the new theme of Difficulties. The wider conceptualisation of recovery by Leamy *et al.* (2011) acknowledges that recovery frequently involves elements of struggle, and it is therefore puzzling that this is absent from the CHIME process element. The presentation of CHIME by Leamy *et al.* (2011) within a wider stage model of recovery does not make explicit any idea of movement backwards and forwards, and the CHIME themes and subthemes are presented a way that accentuates the positive aspects of the processes and appears unidirectional, even if this was not the authors’ intention. In a review of recovery literature, Onken *et al.* (2007) highlight a tendency towards the promotion of individual agency and caution against celebrating only the strengths of those who appear successful, as this can perpetuate the idea that recovery is something achievable by everyone who simply applies themselves. An unintended consequence might be the marginalisation, dismissal or even blaming of people who are perceived as not trying hard enough. This is identified by Arenella (2015) and Rose (2014) as a major concern about services’ adoption of the recovery model: at worst, it promotes a neo-liberal narrative of responsibility in which the individual can always prevail, regardless of social or material circumstances (Beresford, 2015). Brown & Kandirikirira (2007) suggest a division between internal elements of recovery and external ones, and in the context of the current review we would echo the call by Harper and Speed (2012) to consider carefully the difference between empowerment as an individual process, and empowerment as a redistribution of societal power. Just as people might initiate their own recovery, communities and policymakers also play a vital role.

Although the theme of Returning to or Desiring Normality accounted for less than 5% of the coded data, we would argue that it is essential in a critical consideration of recovery. In an echo of the hierarchy of needs (Maslow, 1943), Onken *et al.* (2007) propose that individuals cannot hope to gain control over their symptoms without basic needs such as housing, income and healthcare being met. Furthermore, while moving towards a concept of societal normality is likely to be an aspect of recovery for many people, others might rightly reject the idea that, in order to recover, they must conform to a societal expectation of what is normal (Rose, 2014). For services in the UK, this poses a fundamental question: do we focus resources on assisting people to conform to a society that, as Rose (2014) argues, fears mental ill-health; or do we divert resources from traditional approaches to become more involved in challenging stigma within society (Arboleda-Florez & Stuart, 2012)?

The other two new master themes which emerged in this review may be of particular interest to practitioners seeking to understand how best to apply a recovery approach. Acceptance and Mindful Awareness, and the dyadic theme of Therapeutic Input, both indicate the possibility of specific clinical intervention. It is also notable that self-compassion, which we propose as an additional CHIME subtheme, may have clinical relevance in the psychological treatment of psychosis (Gumley *et al.*, 2010). Whether this involves a mediating relationship with empowerment might be an interesting hypothesis to explore.

Leamy *et al.* (2011) state that the CHIME processes are measurable dimensions of change. While this is theoretically possible (Slade, 2002), it raises questions about method (e.g. what would be a valid measure of identity, or a suitable proxy?) and purpose (would such measurement be of most benefit to service users or researchers?) We suggest that the nature of the extended themes proposed here, particularly Difficulties, might inform more collaborative research into understanding recovery as experienced by service users.

#### 4.2 Methodological considerations

Best-fit framework synthesis was felt to be an appropriate and applicable technique, and colour-shaded presentation of themes offered a visually straightforward approach. We acknowledge that in any qualitative synthesis, just as in primary qualitative research, there is subjectivity: while steps such as co-rating and audit by a second author do not remove this (Yardley, 2000), they do offer a transparent and open account of the process, and the use of an existing published framework, in this case CHIME, further increases transparency

(Carroll *et al.*, 2011). We would argue that reflexive recognition of the partial and situated nature of knowledge is in fact a strength of the qualitative method (Malterud, 2001).

We share the concerns of Dixon-Woods *et al.* (2006) and Cooke *et al.* (2012) about locating qualitative research in electronic databases. While the SPIDER strategy of the latter provided a useful basis from which to work, the manual screening was arduous, and it is concerning that an inclusive database search failed to identify three peer-reviewed papers (Smith, 2000; Spaniol *et al.*, 2002; Tooth *et al.*, 2003). While best-fit framework synthesis is a pragmatic and reasonably rapid method, the time investment involved in any qualitative review may still be off-putting to many researchers. If qualitative research is to improve its standing in relation to quantitative work, addressing the vexed issue of indexing is vital.

### 4.3 Limitations

The use of a priori quality criteria allowed for the systematic consideration of rigour, credibility and relevance (Dixon-Woods *et al.*, 2007; Chenail, 2011). Categorical rather than ordinal scoring was felt to provide some epistemological congruity with qualitative data. Nevertheless, this approach was flawed by the use of the modal rating of quality criteria as the inclusion criterion, which imposed an element of quantification. This is problematic given that each category was not of identical importance: for example, the clarity of the research question is not necessarily as significant a factor as whether the question is suited to qualitative enquiry. While it might have been possible to construct an algorithmic approach to weighting each category (Boeije *et al.*, 2011), this would have been complex and methodologically incongruous. It may have been preferable to avoid imposing any form of quantification upon the categorical descriptors of quality. To avoid purely subjective inclusion or exclusion of articles, a post-hoc sensitivity analysis could have ascertained the contribution of studies identified as weaker (Carroll *et al.*, 2013).

Including only peer-reviewed journal articles excluded a significant amount of what Grayson & Gomersall (2003) describe as ‘grey’ literature (e.g. Brown & Kandirikirira, 2007), and also books (e.g. Romme *et al.*, 2009). Our exclusion of the service-user-led Pitt *et al.* (2007) on quality grounds is in the context of that paper appearing in a peer-reviewed scientific journal. However, there is likely to be a wealth of service-user-generated data in non-scientific publications, and published online. Further synthesis of such data would be a challenging task but a valuable critical step. Where a consumer-focused concept such as

recovery is concerned, it might be argued that the definition of ‘evidence’ should be broadened beyond traditional paradigms.

It may have been of benefit to contact the authors of the papers we included to ascertain whether they knew of eligible works that might have been overlooked. However, such is the nature of qualitative data that a truly exhaustive search might be impractical. Thomas and Harden (2008) advise synthesists to aim for conceptual saturation rather than completeness: we would further argue that boundaries and exclusion criteria are a pragmatic necessity.

The CHIME model was constructed using English-language data, predominantly from studies carried out in the USA and UK. The inclusion in the present review of non-USA and UK studies does not negate the fact that the overall synthesis represents a westernised view; as Slade *et al.* (2012) identify, cross-cultural exploration of recovery would be welcome.

#### 4.4. Conclusion, and implications for research and practice

The induction and analysis of themes by skilled primary researchers remains at the core of qualitative research. Nevertheless, secondary syntheses can augment the primary corpus. The CHIME model (Leamy *et al.*, 2011) provided a workable basis for a qualitative synthesis of recovery processes. Leamy *et al.* (2011) do not claim that CHIME is conclusive, and are clear that recovery will involve a different combination of processes for different individuals. It is in this spirit that we propose that the omission of negative aspects should be addressed. Rethink (2005) suggest that the recovery process can often feel like two steps forward, one step back, and we believe our proposed expansion of CHIME offers a way to incorporate this.

The recovery approach has been criticised as overly professionalised and voluntaristic (Rose, 2014; Harper & Speed, 2012), and it is vital to heed service-user voices. A strength of the research by Leamy *et al.* (2011) is the involvement of service users in an expert consultation panel, and a useful if ambitious endeavour might be to work towards a representative, service-user-led framework to guide services in both the implementation and appraisal of a recovery approach. The initial challenge would be a methodological one, but the democratising effect of social media offers new potential for service users and professional researchers to work together (British Psychological Society, 2012). Efforts are being made to open mental-health research beyond traditional paradigms (McKirdy, 2015), and collaborative work may be of great benefit in challenging stigma and improving services, as

long as all partners are treated equally (Beck *et al.*, 2015; Slade *et al.*, 2014). Ultimately, perhaps the goal of services should be to provide a choice of the best available professional or peer-led services to those that want them (Silverstein & Bellack, 2008). At present we are in danger of imposing professional ideas of recovery on to what was originally a service-user-led concept: it is time to redress the balance.

We propose that it would be beneficial to build on the work of Johnson and Montgomery (1999) and Topor *et al.* (2011), and to examine in more detail the specific difficulties described by people in different recovery situations. Clearer understanding of to what extent difficulties are contextually dependent would be of value in ascertaining how multidisciplinary services can best assist people. While part of this will be about improving psychological treatments that address both the symptomatology and putative underlying aetiology of psychosis (DCP, 2014; Gumley & Schwannauer, 2006), existing evidence suggests that multi-systemic interventions promoting social inclusion are likely to be of great benefit (Onken *et al.*, 2007; Rhodes & De Jager, 2013; Smyth *et al.*, 2011; Warner, 2010).

Finally, it might also be incumbent upon researchers and clinicians to recognise the power and privilege of their positions, and to use that to more loudly challenge the social inequities which are repeatedly linked to serious mental ill-health (Dohrenwend, 2000; Hagan & Smail, 1997; Midlands Psychology Group, 2012). A CHIME-D model of recovery which takes account of difficulties would be a step forward. Political engagement by mental-health professionals to expose and challenge the structural deficits that might be both causing distress and preventing recovery would arguably be a greater one (Harper & Speed, 2012).



## References

- Andresen, R., Caputi, P., & Oades, L. G. (2010) Do clinical outcome measures assess consumer-defined recovery?. *Psychiatry Research*, **177**, 309–317.
- Andresen, R., Oades, L., & Caputi, P. (2003) The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, **37**, 586–594.
- Anthony, W. A. (1993) Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, **16**, 11–23. doi:10.1037/h0095655
- Arboleda-Florez, J., & Stuart, H. (2012) From sin to science: Fighting the stigmatization of mental illnesses. *Canadian Journal of Psychiatry*, **57**, 457–463.
- Arenella, J. (2015) Challenges for the recovery movement in the US: Will its light reach the darkest corners? *Clinical Psychology Forum*, **268**, 7–9.
- Armour, M. P., Bradshaw, W., & Roseborough, D. (2009) African Americans and recovery from severe mental illness. *Social Work in Mental Health*, **7**, 602–622.
- Barker, C., Pistrang, N., & Elliott, R. (2002) *Research methods in clinical psychology: An introduction for students and practitioners*. Chichester: Wiley.
- Beck, R., Mattinson, C., & Sampson, M. (2015) Co-production in relation to the constructs of mentalisation and recovery in personality disorder and mental health settings. *Clinical Psychology Forum*, **268**, 10–15.
- Beresford, P. (2015) From “recovery” to reclaiming madness. *Clinical Psychology Forum*, **268**, 16–20.
- Bird, V., Leamy, M., Tew, J., et al. (2014) Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian and New Zealand Journal of Psychiatry* [Online] doi:10.1177/0004867413520046
- Boeije, H. R., van Wesel, F., & Alisic, E. (2011) Making a difference: towards a method for weighing the evidence in a qualitative synthesis. *Journal of Evaluation in Clinical Practice*, **17**, 657–663.
- Bonney, S., & Stickley, T. (2008) Recovery and mental health: a review of the British literature. *Journal of Psychiatric and Mental Health Nursing*, **15**, 140–153.
- Borg, M., & Davidson, L. (2008) The nature of recovery as lived in everyday experience. *Journal of Mental Health*, **17**, 129–140.
- Bradstreet, S., & McBrierty, R. (2012) Recovery in Scotland: beyond service development. *International Review of Psychiatry*, **24**, 64–69.
- Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, **3**, 77–101. doi:10.1191/1478088706qp063oa
- Brijnath, B. (2015) Applying the CHIME recovery framework in two culturally diverse Australian communities: Qualitative results. *International Journal of Social Psychiatry* [Online] doi:10.1177/0020764015573084
- British Psychological Society (2012) *e –Professionalism: Guidance on the use of social media by clinical psychologists*. Leicester: British Psychological Society.
- Browne, G. (2006) Outcome measures: Do they fit with a recovery model? *Australian & New Zealand Journal of Mental Health Nursing*, **15**, 153–154.
- Brown, W., & Kandirikirira, N. (2007) *Recovering mental health in Scotland. Report on narrative investigation of mental health recovery*. Glasgow: Scottish Recovery Network.
- Burnard, P. (1994) Searching for meaning: a method of analysing interview transcripts with a personal computer. *Nurse Education Today*, **14**, 111–117. doi:10.1016/0260-6917(94)90113-9
- Campbell, R., Pound, P., Pope, C., et al. (2003) Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science & Medicine*, **56**, 671–684. doi:10.1016/S0277-9536(02)00064-3
- Carroll, C., Booth, A., & Cooper, K. (2011) A worked example of “best fit” framework synthesis: A systematic review of views concerning the taking of some potential chemopreventive agents. *BMC Medical Research Methodology*, **11**, 29.
- Carroll, C., Booth, A., Leaviss, J., et al. (2013) “Best fit” framework synthesis: refining the method. *BMC Medical Research Methodology*, **13** [Online] doi:10.1186/1471-2288-13-37
- Center for History and New Media (2014) *Zotero*. Fairfax, VA: Center for History and New Media. Retrieved from <https://www.zotero.org>

- Chenail, R. J. (2011). Learning to appraise the quality of qualitative research articles: A contextualized learning object for constructing knowledge. *The Qualitative Report*, *16*(1), 236–248.
- Cooke, A., Smith, D., & Booth, A. (2012) Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research*, *22*, 1435–1443. doi:10.1177/1049732312452938
- Cook, J. A., Copeland, M. E., Hamilton, M. M., *et al.* (2009) Initial outcomes of a mental illness self-management program based on wellness recovery action planning. *Psychiatric Services*, *60*, 246–249. doi:10.1176/appi.ps.60.2.246
- Connell, J., O’Cathain, A., & Brazier, J. (2014) Measuring quality of life in mental health: Are we asking the right questions? *Social Science & Medicine*, *120*, 12–20.
- Critical Appraisal Skills Programme (2013) *CASP qualitative research checklist*. Retrieved from <http://www.casp-uk.net/>
- Davidson, L., Borg, M., Mann, I., *et al.* (2005) Processes of Recovery in Serious Mental Illness: Findings from a Multinational Study. *Psychiatric Rehabilitation Skills*, *8*, 177–201.
- Davidson, L., & Roe, D. (2007) Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, *16*, 459–470.
- Davidson, L., & Strauss, J. S. (1992) Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, *65*, 131–145. doi:10.1111/j.2044-8341.1992.tb01693.x
- Deegan, P. E. (1988) Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, *11*, 11–19. doi:10.1037/h0099565
- Division of Clinical Psychology (DCP) (2014). *Understanding psychosis and schizophrenia*. Leicester: British Psychological Society.
- Dixon-Woods, M. (2011) Using framework-based synthesis for conducting reviews of qualitative studies. *BMC Medicine*, *9*, 39.
- Dixon-Woods, M., Agarwal, S., Jones, D., *et al.* (2005) Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of Health Services Research & Policy*, *10*, 45–53.
- Dixon-Woods, M., Bonas, S., Booth, A., *et al.* (2006) How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*, *6*, 27–44.
- Dixon-Woods, M., Shaw, R. L., Agarwal, S., *et al.* (2004) The problem of appraising qualitative research. *Quality & Safety in Health Care*, *13*, 223–225. doi:10.1136/qhc.13.3.223
- Dixon-Woods, M., Sutton, A., Shaw, R., *et al.* (2007) Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *Journal of Health Services Research & Policy*, *12*, 42–47. doi:10.1258/135581907779497486
- Dohrenwend, B. P. (2000) The role of adversity and stress in psychopathology: some evidence and its implications for theory and research. *Journal of Health and Social Behavior*, *41*, 1–19.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999) Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*, 215–229.
- Eriksen, K. Å., Arman, M., Davidson, L., *et al.* (2014) Challenges in relating to mental health professionals: Perspectives of persons with severe mental illness. *International Journal of Mental Health Nursing*, *23*, 110–117.
- Estabrooks, C. A., Field, P. A., & Morse, J. M. (1994) Aggregating Qualitative Findings: An Approach to Theory Development. *Qualitative Health Research*, *4*, 503–511. doi:10.1177/104973239400400410
- Grayson, L., & Gomersall, A. (2003) *A difficult business: finding the evidence for social science reviews*. London: ESRC UK Centre for Evidence Based Policy and Practice, Queen Mary University of London. Retrieved from <http://www.kcl.ac.uk/sspp/departments/politiceconomy/research/cep/pubs/papers/assets/wp19.pdf>
- Gumley, A., Braehler, C., Laithwaite, H., *et al.* (2010) A Compassion Focused Model of Recovery after Psychosis. *International Journal of Cognitive Therapy*, *3*, 186–201. doi:10.1521/ijct.2010.3.2.186
- Gumley, A., & Schwannauer, M. (2006) *Staying well after psychosis: A cognitive interpersonal approach to recovery and relapse prevention*. New York, NY: John Wiley & Sons Ltd.
- Hagan, T., & Smail, D. (1997) Power-mapping—I. Background and basic methodology. *Journal of Community & Applied Social Psychology*, *7*, 257–267.
- Harden, A. (2010) Mixed-methods systematic reviews: integrating quantitative and qualitative findings. *Focus: A Publication of the National Center for the Dissemination of Disability*

- Research (NCDDR) – Technical Brief No. 25. Retrieved from [http://ktdrr.org/ktdrr/library/articles\\_pubs/ncddrwork/focus/focus25/Focus25.pdf](http://ktdrr.org/ktdrr/library/articles_pubs/ncddrwork/focus/focus25/Focus25.pdf)
- Harper, D., & Speed, E. (2012) Uncovering recovery: the resistible rise of recovery and resilience. *Studies in Social Justice*, **6**, 9–26.
- Hayes, S. C., Levin, M. E., Plumb-Villardaga, J., *et al.* (2013) Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy*, **44**, 180–198.
- Jensen, L. W., & Wadkins, T. A. (2007) Mental health success stories: Finding paths to recovery. *Issues in Mental Health Nursing*, **28**, 325–340.
- Johnson, B., & Montgomery, P. (1999) Chronic mentally ill individuals reentering the community after hospitalization. Phase II: The urban experience. *Journal of Psychiatric and Mental Health Nursing*, **6**, 445–451.
- Leamy, M., Bird, V., Le Boutillier, C., *et al.* (2011) Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry*, **199**, 445–452.
- Malterud, K. (2001) Qualitative research: standards, challenges, and guidelines. *The Lancet*, **358**, 483–488. doi:10.1016/S0140-6736(01)05627-6
- Marin, I., Mezzina, R., Borg, M., *et al.* (2005) The Person's Role in Recovery. *Psychiatric Rehabilitation Skills*, **8**, 223–242.
- Maslow, A. H. (1943) A theory of human motivation. *Psychological Review*, **50**, 370–396. doi:10.1037/h0054346
- McKirdy, J. (2015) Patient and public involvement in research. *DGP-S Review*, **11**, 15–17.
- Mezey, G. C., Kavuma, M., Turton, P., *et al.* (2010) Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *Journal of Forensic Psychiatry*, **21**, 683–696.
- Midlands Psychology Group (2012) Draft manifesto for a social materialist psychology of distress. *Journal of Critical Psychology, Counselling and Psychotherapy*, **12**, 93–107.
- Monger, B., Hardie, S. M., Ion, R., *et al.* (2013) The Individual Recovery Outcomes Counter: preliminary validation of a personal recovery measure. *The Psychiatrist*, **37**, 221–227.
- Ochocka, J., Nelson, G., & Janzen, R. (2005) Moving Forward: Negotiating Self and External Circumstances in Recovery. *Psychosocial Rehabilitation Journal*, **28**, 315–322.
- Onken, S. J., Craig, C. M., Ridgway, P., *et al.* (2007) An analysis of the definitions and elements of recovery: A review of the literature. *Psychosocial Rehabilitation Journal*, **31**, 9–22.
- Papaioannou, D., Sutton, A., Carroll, C., *et al.* (2010) Literature searching for social science systematic reviews: consideration of a range of search techniques. *Health Information & Libraries Journal*, **27**, 114–122.
- Pesola, F., Williams, J., Bird, V., *et al.* (2015) Development and evaluation of an Individualized Outcome Measure (IOM) for randomized controlled trials in mental health. *International Journal of Methods in Psychiatric Research* [Online] doi:10.1002/mpr.1480
- Piat, M., Sabetti, J., Couture, A., *et al.* (2009) What does recovery mean for me? Perspectives of Canadian mental health consumers. *Psychosocial Rehabilitation Journal*, **32**, 199–207.
- Pilgrim, D. (2008) "Recovery" and current mental health policy. *Chronic Illness*, **4**, 295–304. doi:10.1177/1742395308097863
- Pitt, L., Kilbride, M., Nothard, S., *et al.* (2007) Researching recovery from psychosis: A user-led project. *The Psychiatric Bulletin, The Psychiatrist*, **31**, 55–60.
- Poortman, C., & Schildkamp, K. (2012) Alternative quality standards in qualitative research? *Quality & Quantity*, **46**, 1727–1751.
- QSR International Pty Ltd. (2014) *NVivo qualitative data analysis software, Version 10*. Doncaster, Victoria: Author. Retrieved from <http://www.qsrinternational.com>.
- Rethink (2005) *A Report on the Work of the Recovery Learning Sites and other Recovery-orientated activities and its incorporation into The Rethink Plan 2004-08*. Birmingham: Rethink.
- Rhodes, P., & De Jager, A. (2013) Narrative studies of recovery: A critical resource for clinicians. *Clinical Psychologist*, **18**, 99–107. doi:10.1111/cp.12021
- Roberts, G., & Boardman, J. (2013) Understanding "recovery." *Advances in Psychiatric Treatment*, **19**, 400–409.
- Romme, M., Escher, S., Dillon, J., *et al.* (2009) *Living with voices: Fifty stories of recovery*. Ross-on-Wye, UK: PCCS Books.
- Rose, D. (2014) The mainstreaming of recovery. *Journal of Mental Health*, **23**, 217–218. doi:10.3109/09638237.2014.928406

- Scottish Government (2005) *National Programme for Improving Mental Health and Well-Being: Addressing Mental Health Inequalities in Scotland – Equal Minds*. Retrieved from <http://www.scotland.gov.uk/Publications/2005/11/04145113/51179>
- Scottish Government (2012) *Mental Health Strategy for Scotland: 2012-2015*. Retrieved from <http://www.gov.scot/Publications/2012/08/9714>
- Scottish Intercollegiate Guidelines Network (SIGN) (2014) *SIGN 50: a guideline developer's handbook*. Edinburgh: SIGN. Retrieved from <http://www.sign.ac.uk>
- Shanks, V., Williams, J., Leamy, M., *et al.* (2013) Measures of personal recovery: A systematic review. *Hospital & Community Psychiatry*, **64**, 974–980.
- Shepherd, A. (2013) The need for inclusion of concepts of recovery in clinical trials. *The British Journal of Psychiatry*, **202**.
- Silverstein, S. M., & Bellack, A. S. (2008) A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review*, **28**, 1108–1124. doi:10.1016/j.cpr.2008.03.004
- Slade, M. (2002) What outcomes to measure in routine mental health services, and how to assess them: a systematic review. *Australian and New Zealand Journal of Psychiatry*, **36**, 743–753. doi:10.1046/j.1440-1614.2002.01099.x
- Slade, M., Amering, M., Farkas, M., *et al.* (2014) Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, **13**, 12–20. doi:10.1002/wps.20084
- Slade, M., Bird, V., Le Boutillier, C., *et al.* (2011) REFOCUS Trial: protocol for a cluster randomised controlled trial of a pro-recovery intervention within community based mental health teams. *BMC Psychiatry*, **11**, 185.
- Slade, M., Bird, V., Clarke, E., *et al.* (2015) Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): a multisite, cluster, randomised, controlled trial. *The Lancet Psychiatry*, **2**, 503–514.
- Slade, M., Leamy, M., Bacon, F., *et al.* (2012) International differences in understanding recovery: Systematic review. *Epidemiology and Psychiatric Sciences*, **21**, 353–364.
- Slade, M., Williams, J., Bird, V., *et al.* (2012b) Recovery grows up. *Journal of Mental Health*, **21**, 99–103.
- Smith-Merry, J., Freeman, R., & Sturdy, S. (2011) Implementing recovery: An analysis of the key technologies in Scotland. *International Journal of Mental Health Systems*, **5** [Online] Available at: <http://www.ijmhs.com/content/5/1/11>
- Smith, M. K. (2000) Recovery from a severe psychiatric disability: Findings of a qualitative study. *Psychiatric Rehabilitation Journal*, **24**, 149–158. doi:10.1037/h0095105
- Smyth, G., Harries, P., & Dorer, G. (2011) Exploring mental health service users' experiences of social inclusion in their community occupations. *The British Journal of Occupational Therapy*, **74**, 323–331. doi:10.4276/030802211X13099513661072
- Spaniol, L., Wewiorski, N. J., Gagne, C., *et al.* (2002) The process of recovery from schizophrenia. *International Review of Psychiatry*, **14**, 327–336. doi:10.1080/0954026021000016978
- Stemler, S. E. (2004) A comparison of consensus, consistency, and measurement approaches to estimating interrater reliability. *Practical Assessment, Research & Evaluation*, **9**, 66–78.
- Stickley, T., & Wright, N. (2011) The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part One: a review of the peer-reviewed literature using a systematic approach. *Journal of Psychiatric and Mental Health Nursing*, **18**, 247–256. doi:10.1111/j.1365-2850.2010.01662.x
- Thomas, J., & Harden, A. (2008) Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, **8**, 45.
- Thorne, S., Jensen, L., Kearney, M. H., *et al.* (2004) Qualitative metasynthesis: reflections on methodological orientation and ideological agenda. *Qualitative Health Research*, **14**, 1342–1365. doi:10.1177/1049732304269888
- Thornhill, H., Clare, L., & May, R. (2004) Escape, enlightenment and endurance: Narratives of recovery from psychosis. *Anthropology and Medicine*, **11**, 181–199.
- Tong, A., Sainsbury, P., & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, **19**, 349–357. doi:10.1093/intqhc/mzm042
- Tooth, B., Kalyanasundaram, V., Glover, H., *et al.* (2003) Factors consumers identify as important to recovery from schizophrenia. *Australasian Psychiatry*, **11**, S70–S77. doi:10.1046/j.1440-1665.11.s1.1.x

- Topor, A., Borg, M., Di Girolamo, S., *et al.* (2011) Not just an individual journey: social aspects of recovery. *International Journal of Social Psychiatry*, **57**, 90–99.
- Veseth, M., Binder, P., Borg, M., *et al.* (2012) Toward caring for oneself in a life of intense ups and downs: A reflexive-collaborative exploration of recovery in bipolar disorder. *Qualitative Health Research*, **22**, 119–133.
- Walsh, D., & Downe, S. (2006) Appraising the quality of qualitative research. *Midwifery*, **22**, 108–119. doi:10.1016/j.midw.2005.05.004
- Williams, J., Leamy, M., Bird, V., *et al.* (2015) Development and evaluation of the INSPIRE measure of staff support for personal recovery. *Social Psychiatry and Psychiatric Epidemiology*, **50**, 777–786.
- Wyder, M., & Bland, R. (2014) The Recovery Framework as a Way of Understanding Families' Responses to Mental Illness: Balancing Different Needs and Recovery Journeys. *Australian Social Work*, **67**, 179–196.
- Warner, R. (2010) Does the scientific evidence support the recovery model? *The Psychiatrist*, **34**, 3–5.
- Yardley, L. (2000) Dilemmas in qualitative health research. *Psychology and Health*, **15**, 215–228.

Chapter 3  
**What are the barriers to recovery perceived by people  
discharged from a medium-secure forensic unit in Scotland?  
An interpretative phenomenological analysis.**

Simon R. Stuart<sup>1,2,3</sup>  
Louise Tansey<sup>2</sup>  
Ethel Quayle<sup>1</sup>

<sup>1</sup> Department of Clinical Psychology, School of Health in Social Science, University of Edinburgh  
<sup>2</sup> NHS Lothian

<sup>3</sup> Corresponding author. Department of Clinical Psychology, School of Health in Social Science,  
University of Edinburgh, Teviot Place, Edinburgh, EH8 9AG, Scotland.  
E-mail: simonstuart@nhs.net. Tel: 0131 537 6913

**Contents**

<b>Abstract.....</b>	<b>45</b>
<b>Introduction .....</b>	<b>46</b>
<b>Method .....</b>	<b>51</b>
<b>Results .....</b>	<b>53</b>
<b>Discussion.....</b>	<b>72</b>
<b>References .....</b>	<b>82</b>

This article has been prepared in line with the publication guidelines for the journal Qualitative Health Research, adapted for coursework submission to the University of Edinburgh Department of Clinical Psychology. Information about the journal, including author guidelines, is included in Appendix 4.

**Word count, excluding contents, tables, references and appendices: 14,624**

# **What are the barriers to recovery perceived by people discharged from a medium-secure forensic unit in Scotland? An interpretative phenomenological analysis.**

## **Abstract**

Within mental-health services, the recovery approach provides a strengths-based framework for working with individuals. It is generally characterised by a focus on facets such as hope and empowerment (Leamy et al., 2011): however, these may be less applicable to people within the complex context of the forensic mental-health system (Mezey et al., 2010). Little research exists into recovery principles among this population, particularly following discharge from inpatient care. This qualitative study explored perceptions of recovery, and the barriers to its achievement, as described by eight former inpatients at a medium-secure forensic hospital who were now living in the community. Interpretative phenomenological analysis revealed five superordinate themes: living in the shadow of the past, power imbalances, security and care, reconfigured relationships, and ‘recovery’ as a barrier to recovery. The analysis also allowed for an examination of participants’ values, and a consideration of how these related to recovery processes. Clinical and research implications are discussed in the context of forensic and general recovery literature, and suggestions are made for the development of the recovery approach within forensic services.

**Keywords:** Recovery, forensic, community, qualitative.

## **1. Introduction**

### **1.1.1 The recovery approach and mental health**

The recovery approach to severe and enduring mental illness has become a focus for mental-health services, to the extent that it has been adopted by national policy-makers as a key element of strategy (Scottish Government, 2012). It is commonly defined as a person-centred, strengths-based approach which involves professionals assisting service users to lead a satisfying and valued life, even if symptoms of mental illness are present (Slade et al., 2014). A review by Roberts and Boardman (2013) suggests that this involves a commitment by service users to ‘becoming active and engaged with working on their own recovery’ (p.404). Given that the recovery approach has its roots in a consumer/survivor movement which stood in opposition to medicalised notions of illness and cure (Anthony, 1993; Deegan, 1988), its adoption by services has led to accusations of the colonisation of once-progressive ideas (Beresford, 2015).

Following a systematic review of 97 published papers, Leamy, Bird, Le Boutillier, Williams, and Slade (2011) proposed a conceptual framework for recovery, the central aspect of which is a model of five processes given the acronym CHIME: Connectedness, Hope and optimism, Identity, Meaning in life, and Empowerment. This was used as the framework for a meta-synthesis of qualitative literature by the authors of the present paper (Stuart, Tansey, & Quayle, in preparation), which concluded that an expansion of the CHIME model might better consider the myriad difficulties described by people in recovery. Clinically, approaches to recovery implementation include action plans and service indicators (see Smith-Merry, Freeman, & Sturdy, 2011, for a brief review) but research into outcomes is nascent, perhaps because of the difficulty of operationalising recovery (Silverstein & Bellack, 2008). For services, therefore, recovery better represents a guiding concept than a specific model of care (Roberts & Boardman, 2013).

### **1.1.2 Recovery and values**

In his seminal discursive paper proposing the benefits to services, Anthony (1993) describes recovery as a unique, personal process that may involve service users addressing or changing attitudes, feelings and values. Other review and commentary articles have also placed values at the heart of recovery (Roberts, 2011; Thornton & Lucas, 2011): however, like recovery itself, values are not easy to define. Within contemporary psychological theory there are two predominant approaches. One is a structural model developed through analysis of cross-cultural data (e.g. Schwartz, 2012; Schwartz, 2011), in which values are essentially viewed



as guiding beliefs, the relative importance of which is socially and culturally determined (Schwartz & Bardi, 2001). A universal theory of 10 basic and four higher-order values is proposed, the latter being openness to change, self-transcendence, conservation, and self-enhancement. The other conceptualisation of values is a contextual, behavioural model linked to Acceptance and Commitment Therapy (ACT) (Plumb, Stewart, Dahl, & Lundgren, 2009), in which values are essentially intrinsic reinforcers for each individual: not goals in themselves, but organising principles for action (Lundgren, Luoma, Dahl, Strosahl, & Melin, 2012). Basic examples might be intimacy or personal growth (Plumb et al., 2009). Within the recovery approach, values are described as providing a sense of meaning, purpose and satisfaction (Drennan & Aldred, 2012a): either conceptualisation allows for this, although the behavioural model might offer more flexibility for people to define their own values.

### 1.2.1 Recovery and forensic mental health

Turton et al. (2011) presented a qualitative study of recovery within three specialist services (eating disorders, addictions and forensic mental health), concluding that while the broad themes of recovery were applicable (e.g. those identified by Leamy et al., 2011), specific factors relating to individuals' circumstances were important to consider. This seems particularly pertinent within forensic mental health services. These assess, treat and rehabilitate mentally disordered offenders (MDOs): people with a mental illness, personality disorder or learning disability who are involved, or likely to become involved, in the criminal justice system, often because of violent offences which may include homicide (Jacques, Spencer, & Gilluley, 2010; Scottish Office, 1999). In Scotland, issues pertaining to treatment mean that the primary diagnosis for admission to most forensic services is mental illness, usually psychotic (see Crichton, Darjee, McCall-Smith, & Chiswick, 2001, for background).

An essential aspect of forensic mental health care is the management of any risk posed by MDOs, to themselves and to other people. High-, medium- and low-security facilities offer inpatient care and treatment, usually followed post-discharge by multidisciplinary management in the community, frequently in tandem with legal restrictions on the person's freedom (Mullen, 2000; Roychowdhury, 2011). Such restrictions mean that recall to hospital – or in some cases prison – can be carried out swiftly (O'Sullivan, Boulter, & Black, 2013). In an analysis of 550 discharged cases over two decades at an English medium-secure unit, Davies, Clarke, Hollin, and Duggan (2007) found that 38% were readmitted to secure care (and 49% were reconvicted of an offence). The authors also observed that the risk of death

among the sample was six times that of the general population, with the majority of deaths being suicides or fatalities from other unnatural causes, e.g. misadventure. A previous study (Maden, Rutter, McClintock, Friendship, & Gunn, 1999) observed a 75% readmission rate. A balance of recovery with risk management therefore appears a complex one (Drennan & Aldred, 2012a; Roychowdhury, 2011), including the philosophical complication that while recovery looks for the best in people, risk-focused services are obliged to consider and manage for the worst (Dorkins & Adshead, 2011). Within recovery generally, ‘positive risk-taking’ is suggested as a way in which people can be encouraged to gain control in life (Roberts & Boardman, 2013): however, any risk-taking within forensic services is unlikely to be endorsed by legislature or indeed the public, who may have a disproportionate view of the dangers posed by MDOs (Coffey, 2012a; Mezey & Eastman, 2009).

Nevertheless, there have been various attempts to explore the value of the recovery approach within forensic services. Before considering these, it is also worth briefly noting similarities between forensic recovery and the Good Lives Model of offender rehabilitation, a positive-psychology-based approach which posits that if people can be encouraged to pursue goals and values in socially acceptable ways, both they and society will benefit (Woldgabreal, Day, & Ward, 2014). While research in this area has mainly focused on prison populations, the model’s proponents suggest it might also benefit forensic services (Barnao, Robertson, & Ward, 2010; Robertson, Barnao, & Ward, 2011).

### 1.2.2 Evidence for recovery within forensic services

When considering evidence for the recovery approach, it should be borne in mind that, while efforts have been made to produce valid psychometric measures (e.g. Monger, Hardie, Ion, Cumming, & Henderson, 2013), this presents a further philosophical quandary. If recovery is a unique process (Anthony, 1993), then any effort to operationalise it, or to consider statistical norms, risks invalidating its individual nature (Browne, 2006). Roychowdhury (2011) suggests that personal narratives are essential to recovery research, and qualitative methodologies provide an optimal way of capturing these (Drennan & Aldred, 2012a; Langan, 2010; O’Sullivan et al., 2013).

There is a small peer-reviewed evidence base for the recovery approach within forensic services. A survey-based study of 137 inpatient staff by Gudjonsson, Webster, and Green (2010) found that 98% of those trained in recovery principles – for example the importance of facilitating hope and a sense of control in patients – were positive about the approach, as

were 84% of those who had not received training. Two of the same authors were involved in a subsequent study involving 75 medium-secure inpatients from the same English settings (Gudjonsson, Savona, Green, & Terry, 2011). This found that recovery as measured by their forensic-specific Recovery Journey Questionnaire (RJQ) predicted treatment motivation and engagement, and social inclusion on the ward, above that of traditional quality-of-life measures. The RJQ is grounded in service users' own understanding of the recovery concept, but was validated with small, male-only samples ( $n=4$  and  $n=12$ ) (Green, Batson, & Gudjonsson, 2011). The Gudjonsson et al. (2011) study focuses on how the patient recovery journey fits service desires such as engagement, rather than goals proposed by service users, and neither of these studies provides information about whether the patients themselves viewed the approach, or the outcomes measured, as having any intrinsic value to them.

The single-case narrative by Chandley & Rouski (2014) is co-authored by a professional and a patient in high-secure care in England, making use of the latter's expertise by experience. Echoing Turton et al. (2011), they conclude that the core principles of the recovery approach are of value to this one patient, but are complicated by the forensic context, particularly the offence history and associated stigma. Mezey, Kavuma, Turton, Demetriou, and Wright (2010) provide a closer analysis of the forensic inpatient group ( $n=10$ ) from the Turton et al. (2011) study. Using mixed qualitative methodology, they found that themes of medication, therapy, relationships and security were key to participants' perceptions of recovery, and that traditional recovery concepts such as hope and autonomy were less pertinent. Participants also stated that they felt it would be difficult to find societal acceptance after discharge. A thematic analysis of interviews with 30 patients in a Canadian forensic hospital suggested that recovery involved a complex integration of involvement in programmes, belief in rules, attachment to individuals, commitment to activities, and concern about treatment duration (Nijdam-Jones, Livingston, Verdun-Jones, & Brink, 2014). The first four themes map closely onto a criminological theory of social bonding (Hirschi, 2002), and may be imposed rather than induced. However, the study is notable for its suggestion that understanding more about patients' attachment patterns could be valuable, a point also made in a review article by Mann, Matias, & Allen (2014) based on professional clinical experience.

While each of these studies has individual merit, it can be seen that the evidence base for recovery in forensic mental health is embryonic, and no recovery-focused research has yet taken place in a Scottish setting. The nature of the evidence at present does not allow for conclusions to be drawn, but contextual difficulties do appear prominent within forensic

recovery. Issues relating to offending, legal restrictions and social obstacles appear the most obvious barriers, as summarised in a brief editorial review by Simpson & Penney (2011).

### 1.2.3 Recovery after discharge from forensic secure care

The studies considered above are inpatient-based: as noted by Drennan and Aldred (2012b), recovery after discharge is an area requiring exploration. Barnao, Ward, and Casey (2014) present a rigorous, well-evidenced thematic analysis exploring perspectives on rehabilitation among forensic patients (N=20) approaching discharge in New Zealand, although these were still inpatients or people living in low-security ‘step-down’ cottages at the hospital. Analysis identified both internal (e.g. self-evaluation, agency) and external (e.g. consistency of care) considerations. Coffey (2012a; 2012b) offers a discursive analysis of interviews with discharged forensic patients: this is not situated directly within the recovery concept, but highlights fears about status, stigma and the difficulties of social integration. An unpublished doctoral thesis by Burgess (2011) used interpretative phenomenological analysis (IPA; Smith, Flowers, & Larkin, 2009) to explore the experience of community readjustment in people discharged from an English low-secure unit, identifying broad themes of identity, change and transition: however, using the criteria outlined by Smith (2011), the quality of the analysis is not high. Given that discharge is a potential destabiliser, viewed by some patients with ambivalence (Mezey et al., 2010), further research in this area might be of benefit in understanding what people find challenging, and how services might best assist.

### 1.3. The present research

This study set out to explore individual perceptions of recovery, in particular beliefs about barriers to its achievement, in people discharged from secure psychiatric care. Participants were former inpatients at a Scottish medium-secure unit (MSU), now resident in the community. This unit provides acute and rehabilitation care for male and female inpatients, some of whom may be resident in the secure forensic mental-health system for many years. It had begun to adopt principles of the recovery approach several years earlier, and a working party – including former service users – had been set up to explore and promote recovery implementation (Paden, 2010).

Because the focus of the present research was on participants’ own accounts, qualitative methodology was particularly apposite. The primary research questions were:

- What did participants understand recovery to mean, after their experiences in secure care?
- What did they perceive as barriers to their recovery?

A secondary aim was to explore participants' values: what they perceived as their core values; to what extent these were congruent with their recovery; and to what extent participants perceived their values to be congruent with the values of wider society. It was anticipated that the research would provide a valuable addition to the evidence base for recovery within forensic mental health generally, and begin to address the post-discharge gap highlighted by Drennan and Aldred (2012b).

## **2. Method<sup>1</sup>**

### **2.1 Design**

This was a qualitative study examining the experiences of recovery described by people discharged from forensic secure care, in particular the barriers they perceived. The research method adopted was interpretative phenomenological analysis (IPA), an inductive, idiographic approach designed as a way of exploring lived experience using the philosophical principles of phenomenology and hermeneutics (Smith et al., 2009). Data were gathered through individual interviews, and a semi-structured schedule was constructed to facilitate this (Appendix 5). Given that the medium-secure unit in which they were formerly resident has been a proponent of the recovery approach, it was assumed that all participants would have at least some familiarity with it. However, no formal definition of recovery was used with participants: instead, they were asked to consider what 'recovery' meant to them.

### **2.2 Participants and recruitment**

Participants were former inpatients at a single MSU in Scotland, resident in the community and under the continuing care of a forensic community mental-health team (FCMHT). They had to be 18 or over, able to give informed consent to participate, and not currently experiencing acute symptoms of severe mental illness. Potential participants were identified by the FCMHT, and written assent to approach them was obtained from the psychiatrist in charge of their care, who also confirmed participants' capacity to consent. The initial approach was made by FCMHT staff during routine contact. If people were interested, they were provided with a plain-English Participant Information Sheet (Appendix 6) and given a minimum of 24 hours in which to decide whether they wished to take part. Interviews with consenting participants took place either at an NHS outpatient clinic or at their homes. Participants completed a consent form (Appendix 7) immediately prior to interview.

---

<sup>1</sup> For a more detailed account of the method, please see chapter 4 of this thesis.

Eight people agreed to participate and completed the interview process, of whom five were male and three female. Given that the participants were recruited from a small population, further demographic and diagnostic details will be kept to a minimum, and no offence-related information will be given, in order to ensure anonymity. Participants were aged between 30 and 60 years, with the modal age group being 35-50. All had at one point been diagnosed with a psychotic illness, and in each case admission to forensic secure care had been precipitated by a crisis event. It should be noted that, in general, many people who come into forensic secure care have complex interpersonal and emotional histories, sometimes involving multiple prior trauma (Mann et al., 2014). The mean duration of secure psychiatric admission was 5.5 years, and five people had been resident in high-security care prior to arriving at the MSU. Participants were at different stages in their post-discharge journeys – for instance, some had been discharged for longer than others – but each had returned to the community directly from the MSU via a gradual process of step-down and re-acclimatisation, and was living independently or with minimal support.

### 2.3 Data collection and analysis

All interviews were conducted by the lead author, SRS, who strove for an open, conversational style in keeping with the principles of IPA (Smith et al., 2009). The interview schedule (Appendix 5) was used as a flexible topic guide rather than a script, allowing the interviewer to ensure that all key topics had been covered. Questions were asked in an open-ended way, with use of active listening and reflection. Interviews were recorded using an encrypted, password-protected digital device, and transcribed verbatim by the researcher. The mean length of interview was 36 minutes. Transcripts were analysed by SRS based on the IPA technique recommended by Smith et al. (2009) for a larger sample ( $N > 6$ ): an iterative process in which emergent themes are noted within individual transcripts, clusters of meaning are identified, and structured themes are generated both within and across cases. Ultimately, a smaller number of superordinate themes is produced, aiming to encapsulate the salient aspects of participant experience. These might be informed by psychological knowledge and theory, but theory is not imposed in order to make sense of the data, and themes remain grounded in participants' experience as described (Smith et al., 2009).

Smith (2011) offers a rubric for ensuring quality in IPA research, including transparency about the procedures used, and the demonstration of sufficient evidence for each theme by way of extracts within the finished text. Further recommendations about quality in qualitative work are proposed by Elliott et al. (1999), Yardley (2000) and Chenail (2011), all

of which guided this research. The author EQ is a qualitative researcher with considerable experience: she provided advice on the analytical process throughout, and reviewed the analysis by SRS of four randomly selected transcripts. Within IPA, it is recognised that the process of meaning-making is a dynamic one between participants and researchers, and sensitivity to context is important. To this end, the author SRS has produced a short reflective article addressing contextual issues (Stuart, in preparation).

#### 2.4 Ethical considerations

The study was approved by an NHS Scotland ethics committee and by the health board in which the MSU was situated (Appendix 8). Recordings were stored in a highly secure computer environment at the MSU, in line with local policies and the Data Protection Act of 1998, with passwords known only to authors SRS and LT. No patient-identifiable data were included in the transcripts. FCMHT staff, including the responsible psychiatrist, were kept informed about the progress of the research, including when participant contact was made. Contingency plans were in place in case of any distress or disclosure of risk by participants.

### **3. Results**

The analysis identified five superordinate themes, with between two and four subthemes each. These are displayed in Table 7, which also identifies for which participants themes were present. There are no fixed rules within IPA about how often a theme must appear for it to be considered recurrent (Smith et al., 2009): however, all superordinate themes were present in all participants' accounts, and the majority of subthemes were endorsed by the majority of participants. Transcription conventions are listed in Appendix 9.

Table 7: Themes and superordinate themes, and the participants for whom they were present (shaded cells).

	P1	P2	P3	P4	P5	P6	P7	P8
1. Living in the shadow of the past								
1.1 Dominance of the events that brought me into secure care								
1.2 Trying to make sense of what's happened to me								
1.3 Becoming something other than my past								
2. Power imbalances								
2.1 Dominance of services and systems								
2.2 Not having a say in my own life								
2.3 Being on the edge of society								
2.4 Finding empowerment and trying to fit back in								
3. Security and care								
3.1 Wanting to feel safe and secure								
3.2 Wanting to care	This theme was endorsed by the three female participants. To preserve anonymity, the gender of individual participants is not reported.							
4. Reconfigured relationships								
4.1 Relationships with others are different now								
4.2 Relationships with others are more difficult now								
4.3 Building new relationships with others (and myself)								
5. 'Recovery' as a barrier to recovery								
5.1 Who decides who's recovering?								
5.2 Recovery vs. cure								



### 3.1 Superordinate theme 1: Living in the shadow of the past

All eight participants acknowledged the enormity of the events surrounding their admission to secure care. Cognitive and contextual sequelae appeared to represent significant barriers. This superordinate theme contained three subthemes, of which one – ‘Becoming something other than my past’ – suggested attempts to overcome the problems that they perceived.

#### 3.1.1 Dominance of the events that brought me into secure care

Five participants suggested that memories of these distressing events remained salient, with P7 so uncomfortable that they did not want the interviewer to know anything about their history. These memories were not described in a manner indicating flashbacks: rather, participants’ recollections appeared to be accompanied by secondary emotional appraisals such as guilt and shame (Hellawell & Brewin, 2004). Participants talked of struggling with the past, and of sometimes feeling overwhelmed or trapped by it. Two stated that, while they had no active suicidal ideation, they felt it would be easier not to be alive:

*P3: so much has happened in my past (yeh) to affect me that sometimes if God gave me a choice that whether you want to live or not, then I would say to him: take me away.*

For P3 this is the cumulative effect of a lengthy struggle. This is not described as an active desire to die but as a sense of weariness; a passive wish to be freed by the ultimate judge. Even when people had been judged by the legal system not to be in control of their actions at the time of the event that brought them into secure care, there was a sense that some part of them was still responsible, and they struggled to reconcile this with their sense of self. Participant 2 explained:

*... you are always scarred, that, that, em, you know, <sigh> disruption in your, your, erm, identity [...] there’s no gap in your memory and identity er where that didn’t exist. Ehm (yeh) so, i- it’s impossible to remove it. It’s always there. It’s sliding back and forward and it’s, it’s always th- i- ... even though you’re not held responsible, it’s still you.*

The description of being scarred is vivid: a tangible manifestation of both the events and the cognitive after-effects. P2 was highly articulate, and the slightly fragmented nature of this extract demonstrates the difficulty of trying to explain to the interviewer this wound to their valued sense of self. Other participants also referred to the constancy of difficult memories:

*P8: That, that, I’m trying to put that to the back of my head, eh, because at the end of the day I know I [description of event].*

*P1: I’m hoping [...] the memories and that will all leave me in, in future years to come.*

The persistence of these thoughts and feelings appears to be a recurring barrier for the participants.

### 3.1.2 Trying to make sense of what's happened to me

Seven people spoke of trying to make sense of, or rationalise, what had happened, with the impression being that this was an endeavour to which they had devoted considerable time. (The exception was P7, who stated explicitly that they would not refer to their past.) For all participants, there appeared to be a tension between trying to push away what had happened and trying to accept it. All gave the impression of a lengthy history of difficult events, some beginning in childhood. Some spoke of feeling lucky to have found themselves in the forensic mental health system, and of discovering hope through this:

*P1: ... what I've been through, I've been so lucky to get where I am, I mean ... I ken [people] that have been through maybe less than me and they're sitting with [...] no teeth, no children (mm-hm) ... eh, prescriptions ... maybe no had a chance in life ... ehm ... no aware of the things that are available to them.*

P1 recognises the magnitude of what they have been through and expresses gratitude for where their life is now, even though they also described considerable obstacles. There is the suggestion that forensic secure care gave them the 'chance in life' which had until that point been denied, something generally endorsed by five of the eight participants. P2 was both grateful for and damning of this, expressing anger at not having received assistance sooner:

*... and the thing about [MSU] is, it was the first place to have a nice environment (mm-hm), it has multidisciplinary teams where people work together, everything's geared, and you think: that's brilliant <whispering> but it's too fucking late.*

Substance use was a major element of the histories of four participants. P4 and P6 made similar causal links between substances, mental ill-health and what had happened to them:

*P6: my index offence was, I was-s ... totally ... intoxicated. (Yeh) And I, I can't remember any of it.*

*P4: I just became ... a Jekyll and Hyde with drink and drugs.*

These accounts can be understood as questioning agency and responsibility. Participants' sense of self has been damaged: finding ways to rationalise their behaviour can help restore some self-esteem and allow some distancing from the past (Wilson & Ross, 2001), although it cannot make painful memories disappear. For P2, however, there was also the hope that their devastating experiences could yet provide positives for others:

*... and actually somebody did come to me and say that <pause> their daughter was about to ... was in the same position as I was, and thought of me and didn't do it. And I thought: ffff, that is fantastic.*

This – like, perhaps, P1's recognition of other people's difficulties – points to a valuing of connections with other people; of what P4 sums up as the desire to be a 'good guy'. This value reoccurs throughout the analysis.

### **3.1.3 Becoming something other than my past**

Although the past looms large, participants described a process of moving away from it to some extent. All eight are included in this theme. Three (P1, P5 and P6) explicitly stated that the way they were living now was an improvement on how life had been before they were inpatients, while P3 and P8 indirectly suggested this. P3 spoke of being saved:

*And ... my experiences in the past and ... ehm ... before coming into [secure care], the experience is so horrific that you know I'd be dead if [clinic] didn't pick me up ...*

This suggests that although what has happened in the past might be an obstacle, it is not always an insurmountable one. However, it is notable that P3 ascribes agency to services, not to themselves.

Five participants stated that no longer using substances was paramount. This allowed for a gradual re-engagement with aspects of life they had missed, perhaps for a long time:

*P4: I've no thoughts of drink and drugs or ... ever causing anybody any harm or n- ... quite ... do my own wee thing, I go out with staff for coffees, go to the bookies, things like that.*

*P1: ... every month, on the first of every month, I kind of go that's another month under my belt [...] it's every day at a time but every week I get through I kind of feel better ... but every month I'm kind of rewarding myself because ... I've done another month.*

The 'wee thing' takes on major significance: gains which might seem small to the observer are achievements of which participants are rightly proud. Nevertheless, in both these statements the shadow of their history remains, and this theme is more about moving away from the past than towards any specific future. For some it was appreciated when gains were noticed by other people, particularly family, while for others it was an individual process:

*P7: I had a str-, a period of adjustment to go through (mm-hm), and I had to get used to being on my own and not surrounded by people. But I've got through that and I feel much more comfortable being in the community.*

*P5: I'm true to myself now. I only do things that I want to do (Yeh), just think are right [...] I live my life wi-, sort of reinforcing my own values and that. (Yes.) I don't think I do anything that's illegal, or immoral.*

These extracts suggest that moving on from secure care is a challenging process, requiring personal strength. P5 makes explicit their personal value of morality, and prosocial notions were endorsed by all participants, suggesting they found this way of living rewarding (Barnao et al., 2010). However, this was not always reciprocated.

### 3.2 Superordinate theme 2: Power imbalances

Being under close supervision by services appeared to give rise to multiple tensions, although this was not the only cause of disempowerment. This superordinate theme consisted of four themes, of which one – ‘Finding empowerment and trying to fit back in’ – again suggested attempts to overcome perceived obstacles.

#### 3.2.1 Dominance of services and systems

Seven participants spoke of the dominance of mental-health services, legal systems, or both. There was an impression of being answerable or beholden to other people for everything they did.

*SRS: How do you feel things have been since you left?*

*P4: They've been torture. (Torture.) Torture. (OK.) It's like er I've been in the system 17 year, Simon, (right) and it er it's ... it prolongs, it's like having toothache, it never goes away, it's always constant, seeing people, doing things, everybody wanting a piece of you.*

P4 describes this experience as exhausting and akin to chronic pain. The word ‘torture’ is troubling, hinting that others actively impose this, and the participant’s use of the interviewer’s name contrasts with the impersonal ‘it’ of the system described. Nevertheless, participants – including P4 – also spoke of the value of some of the restrictions imposed upon them, something which will be explored further below. This highlighted a tension:

*P6: ... I mean if I'ds-, if I had a-a-ah, an opinion, or, a thought, or ... an expectation of anything (mm-hm), then I'd speak to [psychiatrist] (yeh). And tell him, what I think.*

P6 denied that anybody was holding them back, but illustrated this using their relationship with their psychiatrist. Their freedom can be seen as contextual, boundaried by what they are allowed to do by the close and constant attention of powerful others – as will be the case for anybody on a legal restriction order. This was observed for small decisions (P6 and P8 spoke

of how applying for or maintaining a driving licence was complicated by their legal and mental-health status) and for larger goals such as P1's desire to be nearer to family:

*I'd like to move to [England] but I'd have to be off an order and it'd maybe take a wee bit of time.*

Like P4, others spoke of the chronicity of their involvement with services, beginning at a young age:

*P3: I mean, I've been in, in and out of hospitals all my life (right) since the age of 18 [...] so that's about over 30 years in and out of hospitals so you do get institutionalised (yeh). And it is difficult ...*

*P8: ... cos I was very young, I (mm-hm), I was like 22 ...*

The subtle shift between the first ('I') and second ('you') person in P3's account suggests that this institutionalisation would happen to anybody with such experiences. Involvement with services is perceived as having become a lifelong, inescapable aspect of these people's lives, and P2 wondered what impact this had on those services' perception of them:

*P2: So there's that kind of ... ach, you know, here they come again, blah blah blah [...] You just feel you're not taken seriously, erm, and it's terrifying to know that people can wield that power.*

The anxiety expressed by P2 appears to result from feeling that they might be viewed by services as a recurrent problem, rather than as a person with individual needs. Regardless of the accuracy of this impression, it appears that they feel not just disempowered but somewhat dehumanised.

### 3.2.2 Not having a say in my own life

While the previous theme concerns the power of systems over people, this theme focuses on people's sense of powerlessness over their own decisions, although there is some contextual overlap between the two. Six participants suggested that their opinions and desires were not understood or were dismissed by others. Partly this was because of legal restrictions, but P2 suggested that it was also important for well-meaning services or other people not to invalidate feelings:

*... seeing somebody else you value, saying the- things about themselves and you think, well, actually that's not right, you're, that's a frame of mind! But you don't challenge that because you know [indistinct] fine well that that's the way they're feeling at the moment [...] You know, you, you're invalidating, you're saying [...] you're not only depressed, you're talking shit.*

P2 suggests that it is understandable for people to feel depressed some of the time, and that this needs to be understood. Given the histories – and, in most cases, offences – of participants, this is a pertinent therapeutic consideration, for instance in terms of how plausible any approach based on cognitive reappraisal might be. P4 seemed anxious about the process of moving on, and bluntly expressed their dissatisfaction:

*I'm quite disappointed in the system because, it's like I'm telling them, I says, the last thing you should do with me is move me into a flat, I says.*

The repetition of 'I says' accentuates their perceived helplessness: they can speak, but they feel they are not heard. They are asking to remain in supported accommodation, but services believe it would be better for them to move on. Again, there is a tension: who knows best, the participant or the service? Participants 1, 2, 3 and 5 also described situations in which they disagreed with the course of care proposed for them, although it is notable that P1 came round to services' way of thinking:

*Ehm, and what are they playing at, and ... you know, and and I had to go along with it but I got the gist of it after a while.*

For services, reintegration involves considering the risk that each person has been deemed to pose, and balancing that with the availability of scarce supervisory resources. For the individuals, however, this professional management appears to represent a further disempowerment; an obstacle to achieving individual recovery on their own terms.

### 3.2.3 Being on the edge of society

This theme arose in interviews with four participants, and appeared particularly salient for those who endorsed it. They spoke of feeling excluded; of struggling to be accepted, and sometimes of giving up trying. In each case this was the result of perceived stigma through being part of the mental health system, the forensic system or both.

*P5: Well like the first few years you're, you're sort of trying to fit in and then you think, I give up. You know, because er, you're just a mental patient to the rest of the world [...] I-, I thought, you know, y-, you can't be honest with people about where you've been. So there's no point in trying to fit in, to that sort of world.*

Participant 5 stated during interview that they believed they should have been in prison, not in forensic secure care. For them, stigma appears more related to being 'a mental patient' than to having offended; this is underscored by the disparaging 'just'. Twice in this extract, P5 suggests that they now inhabit a different world, highlighting a sense of us-and-them

which other participants also acknowledged. For P2, who had become involved with the NHS as an expert by experience, this was sadly also noticeable in dealings with services. They described providing some staff training:

*... and after it ehm one of the ehm I think it was a nursing assistant had come up to the head nurse and said, I can't believe that person was a patient. <Pause> That [person] was a patient. And you think (how) ... after all the training and 'recovery is possible', people still have the us-and-them ... i-, recovery doesn't happen ...*

Here it is other people's attitudes which are presented by the participant as a barrier to social recovery. No matter what the person themselves feels, others unwittingly exclude them, even when trying to be complimentary.

Difference was manifested in other ways. P8 said that although antipsychotic medication had 'turned it around' in terms of their mental health, the hangover-like side-effects precluded them from permanent employment. As the barrier of their symptoms was removed, another arose. For P3, difference was more intrinsic:

*... everyone has erm burn-out periods in their lives, and ([agreement]) you know, we've had er ... I mean, I-uhh ... I'm in a constant burn-out period where every day is a struggle.*

It is not the burn-out itself which is proposed as the problem, but the chronicity. P3 moves from talking about 'everyone' to 'we' to 'I', highlighting that this is their personal experience, not something that anyone else might truly understand. This sense that others could not grasp the enormity of their experiences was most devastatingly summed up by P2:

*... everywhere you go, people (mm-hm) will go, well, ehm, you know, eh, I'm OK, I'm an OK person, you know, I've, I've got my own demons, but I'm not a- ... everybody goes [indistinct; speaking so quickly] but I'm not a murderer, or d'you know what I mean, or I've, I've not done this, you know ... that's the bottom line, that everybody will draw. And you're saying: well, I'm there. I am there. Ehm, so it's, it's ... it's everywhere, it's, ehm, in culture, you know ... e-, everywhere, so you're constantly feeling in, in the ditch.*

This extract speaks for itself. The unwitting day-to-day language and interactions of people who have not experienced such shattering experiences may further alienate those who have.

#### 3.2.4 Finding empowerment and trying to fit back in

This theme was induced from all eight interviews and can be considered a counterpoint – though not a counterbalance – to the power imbalances considered above. People spoke of brief and sometimes more enduring victories, particularly in terms of gaining independence

and control. Frequently this meant finding a sense of normality, either on their own or with support from services.

*P7: I also get social support to go out (mm-hm). And do swimming and s-, go to the cinema (excellent) or whatever.*

Participants 1, 5, 7 and 8 each endorsed the idea of exercise or physical fitness as important. P3 used self-directed support (Scottish Parliament, 2013) to have more say in their social care, while others spoke of the empowerment that came from the most basic freedoms:

*P8: But freed-, aye, it is about freedom, aye, and walking about and that. Yeh, yeh. Going for walks at night and that.*

The meaning attached to this again highlights a distance between the participants and a society that has not shared their disempowerment. For someone who is legally restricted, even a small sense of control may be highly valued, and normality was viewed as a significant achievement by all participants given their uncommon experiences. However, for P2, who was working with services, this was not enough:

*... you're starting to get well when you start to get angry. Because you realise that there's actually things people could have done [...] you think, well, what the hell's the point? It's too late now. So there's, there's a bit about that, and that's why I wanted to [...] get involved (mm), you know ...*

Becoming involved with services has given them a way of answering their own question 'what the hell's the point?' The emotional appraisals of the past, and the sense of injustice, remain, but their response is to change their behaviour in keeping with their values of connection and equality:

*... basically it's about umm trying to erm provide a ... I don't know, a bridge between, erm, nurses and and peo-, you know [...] so people can speak to each other as equals [...] so people who need help can ask, and people who want to help can help.*

Through such discussions, it was possible to begin to instantiate a wider sense of the values that participants associated with recovery. For P2 and P3 these appeared to include connecting with and caring for other people, and equality of care; for P5 honesty and integrity; and for P4, P6 and P8 being part of a community to which they felt they were contributing. P7 talked of the intrinsic reward that came with educational pursuits, while P1 spoke of wanting to become closer to God, and through that empowerment to renew a shared connection with others:



*Because when you've got God on your side you're no' on your own because God's there, he's there for everybody.*

### 3.3 Superordinate theme 3: Security and care

This superordinate theme contained two themes. It highlights the multiple meanings of the words 'secure' and 'care': how the former might apply to psychological concepts such as attachment and resilience as much as it does to risk, and how the latter might apply to looking after as much as to medical treatment.

#### 3.3.1. Wanting to feel safe and secure

Within the previous superordinate theme of power imbalances, there is an impression that participants often wish to escape from close supervision. Nevertheless, all eight also indicated an ongoing desire for security in some form, and some were more confident than others about their ability to provide this for themselves. When P3 was asked what was their biggest struggle day-to-day, they replied:

*Just ehm not to be looked after, you know, and just to be in a safe environment where everything's done for you and y-you just have to eh get up and you're around people all the time (yeh). You know, I mean, when you're out you're mainly on your own.*

During inpatient secure care there was a shift of responsibility away from participants and on to staff, which P3 seems to have found a relief. Upon discharge, responsibility has been returned, and they have struggled. For P3 it matters to have people around them, and this is much harder in the community. Indeed, the implicit suggestion is that they do not feel entirely safe. P4, living in supported accommodation, echoed these concerns:

*... I feel safe and secure in this house [...] And that's how it-u keeps me away from drink, keep-uh drugs, because I'm safe and secure. When I stayed myself and that I became unwell and I didn't feel safe and secure and took more drink and drugs to cope with it.*

There are questions here of resilience and responsibility. P4 seems to be suggesting that their capacity to contain their own emotional responses is limited, and that they are dependent on an external containment which they perceive as being provided by peers, services and indeed their legal restrictions:

*I don't want the restrictions lifted, and I keep saying that to them, because ... why fix something that doesn't need mended? You take you off restrictions, you get stressed, you go back to drink ...*

Again, the use of the second person suggests they might see this as applicable to anybody in their situation. P4 later stated that they felt in control of their decision not to use substances. This control therefore appears contextual, and they fear what might happen if the context is changed against their will.

Reliance on others to some extent was described by seven of the eight participants, whether this was family for support, services for support, services for medication or a combination of these. Of all the participants, P5 was most comfortable on their own, but even they valued the security that came with routine. They described a regular visit to a place that they enjoy:

*What I like about this place is, the only choice I've got to make when I get up in the morning is go left or right [...] And that's it. That's the only decision I've really got to make that day. (Right) And ... before five o'clock, because of ... it getting dark, that's my day finished.*

This is a simple, serene situation in which there are clear external boundaries (the roads; nightfall) and individual responsibility is at a minimum.

P1 said they appreciated having people 'holding my hands' as they explored what was available to them after discharge. P3, who had a longer experience of inpatient and outpatient care, used a similar metaphor, speaking for themselves and those they saw as being like them:

*... somehow throughout our lives we've lost that sense of being able to look after the basic necessities like eating well, er you know er sleeping well, exercising well, you know, all these things that, m-, er a sane person might know, knows to do and to execute. We're not being able to do that (yeh). And so we need a helping hand with all those things.*

P3 appreciated the care that was being offered by services, friends and family, and repeatedly stated how lucky they were to have it, but they wanted more. In the extract above, they present themselves as different from the majority: helpless and almost childlike. In the next extract, P3 expressed directly an ambivalence to which other participants alluded, a desire to be securely looked after at the same time as wanting to be free:

*I mean, ideally if I could come in for a, er, a two-week break, er, into the hospital, I mean, that would make sure that ... I don't want to be in hospital, and when I'm out I want to stay out. (Yeh.) Um, but, er, having said that, I do come to [hospital tearoom] (mm-hm), I do attend clinics at [unit] still, so there is involvement, they've not let ... there's no s-, the safety net isn't gone.*

Here they move quickly from relishing admission to rejecting admission, settling on the compromise of regular outpatient care. Hospital represents both a place of confinement and a place to which one can escape. Inpatient admission offers the rare luxury of security and care, but at the cost of freedom: at times it appears that this is a difficult choice to make.

### 3.3.2 Wanting to care

This theme arose from the narratives of the three female participants only. In the interests of anonymity, supporting extracts are not directly attributed in this section.

All three women recognised the many challenges of their own situations, yet each spoke about the importance of helping those whom they perceived as less fortunate. One spoke of how she and her family were rallying round someone who was having difficulties – an echo of the efforts that the family had previously made to try to help them. In this way the desire to help can be seen as repayment. However, two participants spoke of their desire also to help people they did not know:

*I mean the other day I took an asylum seeker for a meal out [...] people are human beings, you can't just, because ... they haven't got the same standards as you, you don't lose your value in, in all this, they're human beings ...*

*I used to argue with my, my folks, they'd say don't give them any [indistinct: money?], they'll only spend it on drink. And I'm saying, well, maybe if it gets them from this day to the ... what's he going to do, put it in a deposit down on a house?*

The line at the end of the first extract points explicitly to an overarching value placed on shared humanity, which recurs throughout this analysis. Previous themes are reframed here as applying to others instead of – or as well as – the participants: people being prisoners of their past, and power imbalances. In these vignettes, the participants are in a rare position of relative power, and they wish to use this benevolently.

## 3.4. Superordinate theme 4: Reconfigured relationships

There were three themes within this superordinate theme, each endorsed by all eight participants. The third theme is more appetitive, and again explores participants' attempts to overcome differences and difficulties.

### 3.4.1 Relationships with others are different now

People spoke of having to renegotiate relationships with family, friends and others, their status as forensic patients affecting both how they perceived other people and how they

expected others to perceive them. Participants 1, 3 and 8 stated that familial relationships had improved following their inpatient treatment, though this was not straightforward:

*P3: ... my family now, they ring me every week (mm-hm), I have a good conversation with them and I speak for an hour, you know, and (mm-hm) an hour at a time to them, and I tell them what's going on. If I feel upset, I know that um they don't want to see me in the state that I was in (mm-hm), mouth dribbling and overweight and you know, drugged up to the eyeballs ...*

P3 emphasises the fact that they speak to their family for an hour as if this is a newly formalised experience. There is a sense that recovery is as much for the benefit of their family as it is for them, reinforced by the graphically critical way they describe themselves when unwell. Through this we can infer a sense of duty, or at least responsibility, to the family: this is reinforced by the way family is described as a homogeneous, powerful unit.

P1 also alluded to responsibility, but saw it as bidirectional:

*P1: If she starts making an effort to get her life together, my [relative], ehm if she starts making a bit of an effort then I'll make an effort with her, but it's like that same old, is the word cliché, but it's, it's ... if you don't ... if somebody doesn't help themselves, you'll no' help them.*

This is a participant who has 'helped themselves', and who feels that they have made significant changes. They had been enthusiastic about encouraging this relative to join them in a particular activity, but it might be that they are beginning to move in a different direction from some of the people in their past. For P5, P6 and P8 this sense of distancing was more pronounced, and the descriptive phrase P8 uses at the start of this extract is compelling:

*I've grew up at the wrong life, eh? And I've hanged about all of the dodgy neighbourhoods and that, an- ... I've seen guys since I've been out and they've been al-, oh gi's your number and I says look mate, I'm not giving you my number, and they're like, how no? I says, because I'm wanting a, I'm, I'm doing my own thing now, eh?*

Breaking away from the 'wrong life' and the people associated with it is a relational and emotional challenge but also a practical one. As P8 explains, they cannot help but meet acquaintances with whom they no longer wish to associate, adding an extra complication to the process of recovery. P5 took steps to avoid this by moving away:

*Yeh, I've got away from like the environment and-d the family I had and the people that I was cutting about with (right). Just really wasn't good.*

They contrasted this with advice they said they had been given by professionals to stay in touch with family, again highlighting the tension between individual and service-led concepts of recovery.

As community patients, all participants were in ongoing relationships with staff: even those who expressed ambivalence about services in general stated that they had a good relationship with their community psychiatric nurse. Participant 3 explicitly stated that they felt a familial connection with their clinical team, and four further participants gave examples of situations in which professionals had adopted a parental role.

*P6: I've not had a drink for 12 years. (That's fantastic.) I know. And even the GPs think that's good an' all. (That's fantastic.) He says you're doing well, son.*

The participant's pride in this has a guileless, childlike quality, accentuated by the use of 'son' (whether or not this was the GP's actual language). It is also notable how the interviewer moves to praise – the dynamic here is briefly paternalistic.

Participants spoke about their perceptions of community and society. Some expressed the wish that people would do more to help each other but there was a general sense of agreement that, in P7's words, 'most people are kind and honest', and every participant expressed prosocial views. P5, who lived the most solitary life, expressed them from a distance:

*But you see a lot of nice people out there, y', you know. D-id, I'd, I'm, sort of, what d'you call it, off stage and looking at people (mm-hm) and you see them conducting their everyday lives, and I get quite a buzz out of that ...*

Although they feel they can no longer play a part on the societal stage, and watch instead from the wings, they nevertheless care about other people and take pleasure in their happiness. This is a complex relational situation and not one necessarily accounted for by traditional recovery concepts.

### 3.4.2 Relationships with others are more difficult now

Relationships were not just different: every participant gave at least one instance of a relationship being more difficult after discharge, posing another barrier to recovery. Some relationships now required additional effort:

*P3: I've involved my family (yeh), I've involved my friends (right), I've involved the services [...] I've built relationships with everyone, you know. So there's a lot of hard work that goes into it.*

Here P3 is talking specifically about their need for care, and the implication is that if they did not put in the 'hard work' themselves, they would not have the support they do. This might be an ongoing challenge for someone who has struggled with the move back to the community. P6 spoke of a family member with whom they had a troubled relationship, and who seemingly refused to countenance the idea of any kind of recovery:

*... he's no very supportive. He's-he doesn't understand mental illness either. He doesn't realise that there is tablets that help you.*

The quality of the relationship between this person and P6 before they were hospitalised is unclear, but the situation appears to have worsened subsequently. Like others, P6 desired support after their experiences: paradoxically, the nature of those experiences makes support less likely from this relative. Conversely, P2 spoke of family who tried to offer support but – echoing comments about invalidation – failed to understand that there was nothing they could have done at the critical moment:

*... it's very difficult to explain to people after it, people would try and come up to me and, and, and ... ehm ... try and say, why couldn't you let ... ehm ... us look after ... as if I had [clears throat] ... my actions had been deliberately against them ...*

Even in a caring relationship, difficulties exist, and other people's perceptions cannot necessarily be challenged. Although P2 said that they felt supported, events surrounding their hospitalisation had affected their wider family. Again, recovery might be hindered by the way that other people respond and behave, and familial support systems may contain fragilities, no matter how strong they appear.

As previously noted, all participants expressed prosocial views. Four participants, however, talked of times when such inclinations had to be tempered, as illustrated by P5 and P2, both discussing instances when they had met new people:

*P5: I was saying, there are things about me that you probably ... (mm-hm) wouldn't like to hear and all that, and er I'll need to tell you before I'd even go out on a date with you ...*

*P2: ... and it's very difficult for me because I'm, I'm a very friendly, sociable person, so (mm-hm) I'll be out and I'll be talking to people and of course they'll start asking questions, you know, are you married, y'know, y- ... and it's, and where's this gap for so many years ...*

Both faced a similar dilemma in deciding whether or not to disclose their past.

*P5: ... I would like to be absolutely honest with people but ... y's, ehn, but when I was with people, their reaction was like terrible.*

*P2: ... my instinct is to be honest and truthful, but I can't, I can't (right) do that to everybody, because once that information's out, people can do whatever they want.*

Both participants value honesty and authenticity, but both feel that, because of the context in which they find themselves, this is not always possible. There may be occasions when, to protect themselves from adverse reactions, they have to act against their prosocial values. Like all the participants, their relationships are circumscribed by the events of their past.

### 3.4.3 Building new relationships with others (and myself)

Despite the concerns and difficulties analysed above, seven participants described examples of positive relationships formed with other people post-discharge. Participants 1, 3 and 8 spoke of improved relationships with family, while P4 spoke of their pleasure at being treated 'just as normal' by others:

*... when people are talking to you as if they're talking to th-the guy next door. (Which ...) They do-, they don't think, I'd better watch what I'm saying to him, and he's acting odd, or-r his behaviour's er-irrational. Now I'm just ... that.*

All participants except P4 and P5 suggested that they had formed positive relationships with peers: people who had been through similar experiences and were living in similar contexts. Given that many of the barriers described above relate to other people's lack of understanding of what the participants had experienced, there are obvious advantages to such relationships. Peer support was also formalised for some participants in group therapy, and for P1 the sharing of experiences was invaluable:

*So 10 years of my life was one guy who was talking about his life, he spoke about my life. So I was able to connect with that [...] Sitting in they groups is powerful.*

Once again, connecting with other people is valued. This experience seems to have been both powerful and empowering.

P5 was the only person not to describe any valued interpersonal experiences post-discharge, but they did indicate an improved relationship with themselves. They had deliberately broken all ties with their past, rejecting not only their former behaviour but their former attitudes to the wider world (the 'it' in this extract):

*... back then I did what everybody else did and I took the drugs and the alcohol and (mm-hm) blocked myself off from it. (Mm-hm) 'Cos I'm thinking it's shit. Everybody says it's shit so it must be shit.*

They had subsequently found a sense of peace through increased engagement with their surroundings:

*I'm embracing my world, which (yeh) is the world around me [...] I've noticed so much in the last [number of] years in particular, than I've ever noticed in the previous [decades] ...*

They spoke of a conscious engagement both with the natural world and with day-to-day activities such as doing their shopping. Despite their rejection of formal therapy, what they were describing was in effect mindful engagement with the present (Kabat-Zinn, 2003). Ideas of intrapersonal growth and a new understanding of the self were also endorsed by participants 1, 2, 6 and 8, although in these instances they were more clearly associated with direct therapeutic input.

### 3.5. 'Recovery' as a barrier to recovery

The fifth and final superordinate theme, induced from all eight interviews, consists of two themes concerning the idea of recovery itself. The sense that people make of the concept may, paradoxically, be an additional barrier to its achievement.

#### 3.5.1 Who decides who's recovering?

Seven people alluded to a tension between services' conceptualisation of recovery and their own. The only participant who did not was P2, who had taught recovery courses to other people. The rest described instances in which 'recovery' appeared to be a concept owned or even imposed by others, as opposed to one generated by and belonging to them. As such it could be perceived as a goal to be met, rather than an ongoing process.

*P3: [Staff member] er normally talks about recovery (mm-hm). And although I don't feel like I've recovered or am recovering, ah, I'm sure the progress seen by everyone is recovery. Although I don't feel it myself.*

*SRS: [...] what would you say that concept of recovery means, to you?*

*P3: When you're enjoying life, you're (mm-hm) erm enjoying getting up in the morning, um (mm-hm) ... when errr ... you're participating in uhm [pause] er ... things ... out there, um ... like ... But I, I think, i-, eh, for me anyway, I, I don't think it's a recovery, it's, it's ... eh ... it's a means to an end (mm-hm), just to pass the day, just to get through the day.*

P3's faltering syntax suggests that the question of what recovery means is not an easy one to answer. They recognise that they are making progress in the eyes of others, and that some



aspects of what they are experiencing may fit the definition of recovery as described by staff, but this is not ‘felt’, possibly because intrinsic reward is missing. Again, the impression is of movement away from aversive stimuli such as cognitions pertaining to the past – doing something ‘just to get through the day’ – rather than appetitive movement towards what is desired, and one problem may be that what is desired is not clear. P4 also highlighted a discrepancy between practical and emotional aspects of recovery:

*Because they say I’m that well [...] and able and capable and all that. But they only see the fi-, the practical side (mm). They don’t know the emotional side. (Right) And that’s what gets me.*

P4 considered themselves ‘recovered’, and their fear was that a change in context would permanently undo this. Recovery is therefore viewed as a discrete event, not as a process involving both forward and backward steps. P4, like participants 6 and 8, made reference to recovery involving stepwise movement in one direction, and these three people each gave the sense that progress could be measured in terms of how many groups or sessions of therapy had been attended. This sits uneasily with any definition of recovery as involving valued social and personal outcomes.

For P5, recovery was a concept that simply did not apply:

*I just don’t accept that as a word. (OK) You know, what I had to do after my index offence was sober up. An- (right) That’s what I had to do. And so once you’ve did that (mm-hm), that was that ... As far as I was concerned.*

*SRS: I suppose some people would see that process (mm-hm), of sobering up, as ... recovery.*

*P5: Yeh, but I’d sobered up in 24 hours.*

This leads to the second element of this superordinate theme.

### 3.5.2 Recovery vs. cure

That recovery is not synonymous with cure is an essential facet of the consumer definition (Anthony, 1993). P2 appreciated that this could be a difficult distinction for people to understand:

*... I’ll say recovery does not mean cure, just like if you ... supposing your arm chopped off (mm-hm), ehm, you will recover but you won’t have your arm back.*

Objectively, this is an excellent metaphor for consumer recovery, but P2 has become a teacher within the model. The other participants are less invested in recovery per se, and five

indicated that, for them, recovery meant being asymptomatic: a focus on ‘recovery from’ at the expense of ‘recovery in’ (Davidson & Roe, 2007). P7 stated:

*I can control my symptoms and do things that I like to do*

yet reiterated that:

*I don't feel as though I've made much of a recovery yet. I've still got mental-health problems.*

There is a sense of mutual exclusivity here: recovery can begin only when their mental-health problems end. Aspects of P7's diagnosis mean they were likely to be more rigid in their approach to recovery, but this view was echoed by others:

*P3: ... and now, seven years on, I'm still not, not recovered from ... my past experiences ... SRS: [...] do you think those past experiences are something it would be possible to recover completely from or not?*

*P3: No, not for me. (OK.) I think er ... not for the many people that er come through [MSU].*

Here, the operative word as introduced by the interviewer is ‘completely’. P3 states, understandably, that what they and others have experienced is too overwhelming to allow for complete recovery. This should not preclude progress within the broad recovery paradigm: it is about an ongoing process on people's own terms. However, as the extract at the beginning of this superordinate theme indicates, this is not something that P3 feels to be feasible either. ‘Complete’ recovery – binary, all-or-nothing – appears to be what the majority of participants desire, and the process-driven, individualised consumer model does not necessarily feel like an adequate alternative.

## **4. Discussion**

### **4.1 Summary of results**

This study explored perceptions of recovery described by eight people formerly resident in a medium-secure unit in Scotland. The primary research questions were: what did participants understand recovery to mean after their experiences in secure care; and what did they perceive as barriers to their recovery? Secondary questions asked about participants' values; to what extent these were congruent with their recovery; and to what extent they thought they were congruent with the values of wider society. Five superordinate themes emerged from an interpretative phenomenological analysis: living in the shadow of the past, power imbalances, security and care, reconfigured relationships, and ‘recovery’ as a barrier to recovery. Together, these support the general suggestion that recovery within forensic

settings is a complex and challenging process (Mann et al., 2014; Mezey et al., 2010; Simpson & Penney, 2011), although it should of course be borne in mind that the study specifically explored barriers.

#### 4.2. Values and positive aspects of recovery

Asking participants about their values also allowed for an exploration of what they perceived as positive aspects of recovery. Three superordinate themes – living in the shadow of the past, power imbalances and reconfigured relationships – contained subthemes that suggested recovery as it is traditionally conceptualised (Leamy et al., 2011). These were ‘becoming something other than my past’, ‘finding empowerment & trying to fit back in’, and ‘building new relationships’, endorsed by all participants (Table 1).

If the CHIME framework of Leamy et al. (2011) represents a summary of what are broadly accepted as the appetitive elements of recovery, participants’ prosocial values map most obviously onto the theme of connectedness. Even P5, despite their distancing from other people, saw value in others’ happiness. The helping role desired by the female participants echoes the concept of generativity within criminological theory: a desire to give back to society, in keeping with what might be a fundamental value of caring about other people (Maruna, 2001). Within CHIME, helping others could also be seen as an example of meaningful activity. All eight participants reported finding some element of empowerment in what they were doing, although this appeared difficult to attain. Even if values-congruent action is accepted as a lifelong process (Hayes & Pierson, 2005), the participants’ context provided additional challenges to the achievement of meaningful goals: most people, for example, would not face legal restrictions on moving to another part of their country of residence in order to be nearer family, as did P1.

Happily, all of our participants displayed hope and optimism in some form. Even P4, who appeared most fearful about their future, found some happiness in their present situation. However, none of the participants described a straightforward process of positive thinking and aspiration: P8, perhaps the most optimistic, still described significant setbacks along the way. This is in keeping with a more balanced, difficulties-aware conceptualisation of recovery processes.

Issues of identity are arguably the hardest to define within the recovery approach. In the present research, they are maybe best summarised by the difficulties in achieving what Smith

& Garcia (2012, p.111) call ‘the move from mentally disordered offender to person’. Identity is frequently an overarching theme in IPA research (Smith, 2004) and will be considered further below.

#### 4.3. Barriers to recovery

For the participants, recovery is not only about mental illness, or mental illness and substance abuse: it is complicated by what Mezey et al. (2010) call the dual stigma of historic mental illness and historic offence. While this is primarily contextual, there is an intrapsychic element too: participants were dealing with the cognitive sequelae of their histories, frequently in the form of difficult emotions. As with all undesired cognitive events, active attempts to suppress these may have a counterproductive effect (Wenzlaff & Wegner, 2000) and it is likely from some accounts – for instance P2, P3 and P7 – that there was a tendency towards depressive rumination as well as adaptive reflection (Watkins, 2008). Making sense of what has happened appeared to be a recurrent challenge, conflicting with the forward-looking notions of optimism and empowerment inherent in the recovery approach. Indeed, considering their histories, some participants may be experiencing cognitive aspects of complex trauma (Courtois, 2004; Herman, 1992). Trauma may be exacerbated by – and indeed exacerbate – guilt and other emotional appraisals related to the event that brought them into secure care (Crisford, Dare, & Evangelini, 2008; Gray et al., 2003). Given the increasing focus within clinical psychology on trauma-informed work (DCP, 2014), this suggests a focus for further research within the recovery approach.

Dorkins & Adshead (2011) propose that, because of their histories, the previous identities of some forensic patients are spoiled beyond recovery. In this case – as Arenella (2015) asks about recovery in general – there is a semantic question: what is it that we hope people will ‘recover’? Generally, participants wanted to look forward, even if that was difficult: as Dorkins & Adshead (2011) suggest might be the case generally in forensic recovery, the challenge is building a new identity, not rebuilding or redefining an old one. Whether concepts of identity within the recovery approach are sophisticated enough to account for this is unclear. The superordinate theme of power imbalances also suggested a loss of agency – perhaps even of personhood – as perceived by powerful others: the move to what Coffey (2012a) describes as an enduring risk identity. Even if forensic patients could recover their former identity, therefore, this might not be perceived as a desirable outcome by services.

The review by Mann et al. (2014) states that problems with attachment are prominent within forensic populations. Our research did not consider participants' childhoods: nevertheless, traumatic experiences over the lifetime may be related to increased attachment insecurity (Cozzarelli, Karafa, Collins, & Tagler, 2003). In an attachment context, complex patterns of care-seeking – for example the ambivalent attitude to services explored in the superordinate theme of security and care – become more understandable (Courtois, 2004). Mann et al. (2014) further posit that relational difficulties linked to insecure attachment might make it difficult for forensic patients to articulate their needs, and that they may perceive encouragement to take personal control as the removal of the security they desire: something demonstrated within the participant narratives. Laithwaite and Gumley (2007), in a qualitative study with inpatients at a high-secure hospital, propose that some people saw the hospital as a secure attachment base, and suggested that this might be of therapeutic benefit: however, this once again raises the question of what happens after discharge. For some participants in the present study, discharge felt like a severing of links, and continued contact with the forensic community team was no substitute for the security and care provided on the ward. Furthermore, within infant attachment theory, a secure base allows for the exploration of the wider environment, which involves some degree of risk-taking (Carr, 1999). Forensic patients are unlikely to be encouraged to take risks, and the community team's role is akin to that of an over-protective parent. At the most fundamental level, a power imbalance is enshrined within the patient-staff relationship, preventing our participants from the kind of fully agentic, self-efficacious empowerment which the recovery approach encourages (Silverstein & Bellack, 2008).

Ironically, then, people may be disempowered by discharge from secure care. They remain beholden to the structures and strictures that dominated their lives as inpatients, but without the welcome containment offered by the ward; furthermore, they may be prevented from engagement in employment or other meaningful activity because of symptoms, medication side-effects or culturally embedded public attitudes (Coffey, 2012a). Smith and Garcia (2012) state that being accepted by, and involved in, one's community is a vital aspect of social recovery: for our patients, this was likely to be a significant challenge, as the superordinate themes of power imbalances and reconfigured relationships suggest. Indeed, for some participants the only way they could conceive of recovery was to deliberately distance themselves from the communities they had once known. P2 and P5 both stated that they felt acceptance by other people was only possible if they acted, at least some of the time, against their personal values of honesty.

The question might therefore be asked: within a recovery context, are we asking too much to expect participants' individual values and motivations to outweigh the pressures of context? The recovery approach as it is commonly conceptualised is agentic and requires personal responsibility for change (Roberts & Boardman, 2013). It would be understandable if people disempowered by their situation and struggling with the burdens of the past did not readily accept this responsibility. This is further reflected in the tensions inherent in the final superordinate theme, 'recovery' as a barrier to recovery. The majority of participants appeared not to desire recovery so much as reinvention or cure.

#### 4.4 Clinical implications

It is not possible simply to generalise from the present research to any wider population of forensic outpatients: IPA seeks to illuminate the experiences of participants, not to present theories (Smith et al., 2009). However, Polit and Beck (2010) suggest that the informed reader can evaluate the extent to which the results of such a study may be transferable elsewhere: on that basis, and in the context of existing literature, some clinical implications might usefully be explored.

The findings remind us that recovery is not a straightforward or linear process (Stuart, Tansey, & Quayle, in preparation). All five superordinate themes support this interpretation, and it may prove a useful rubric for clinicians in the forensic mental health system. All eight participants described ongoing elements of struggle and difficulty, both cognitive and contextual, alongside positive experiences of recovery. Optimism is a fundament of the recovery approach (Leamy et al., 2011) but this might be overly seductive for professionals. Recovery may not look like professionals want it to, and realism is vital. Just as recovery does not preclude symptomatology (Anthony, 1993), nor might it preclude more acute episodes of distress in people most severely or chronically affected by mental ill-health.

Our results could be interpreted as pessimistic about the recovery approach in forensic mental health, where it might be expected that many service users have had particularly severe episodes of illness and possibly associated trauma (Mann et al., 2014; Witvliet, Knoll, Hinman, & DeYoung, 2010). However, regardless of the barriers that participants perceived, we would propose that the approach is fundamentally valuable: it offers people a broad framework for values-congruent behaviour and, vitally, encourages staff always to think about patients as people (Gudjonsson et al., 2010). Indeed, this might encapsulate the most

important implication for services: the necessity for informed realism about what each individual can achieve, and an honest, ongoing dialogue with them about this.

Recovery had different meanings for different participants, and one response might be that the approach needs to be more clearly defined, perhaps through further psychoeducation. However, this might be too simplistic. An essential point, summarised by P3, is that recovery – however it is defined – appears contingent upon tangible reinforcement, and in anything other than the short term that reinforcement must be intrinsic. Recovery needs to be experiential as well as propositional: put simply, people need to feel it as well as be told about it. This did not always appear to be the case for our participants. Fostering intrinsic reinforcement by exploration of patients' values might be a way to address this (Wilson, Sandoz, Kitchens, & Roberts, 2011). Acceptance and Commitment Therapy is a technique in which concepts such as mindful awareness and acceptance – as demonstrated, seemingly unwittingly, by P5 – can be encouraged with the ultimate goal of changing or maintaining behaviour in line with one's values (Hayes et al., 2006). As noted in the superordinate theme of Power Imbalances, therapeutic methods based on cognitive restructuring may be particularly challenging given the nature of forensic patients' experiences, and the ACT approach of cognitive defusion may offer a workable alternative for some patients. However, substantial research is needed into its effectiveness with this population (Howells, 2010); furthermore, as described above, the problem of contextual obstacles to values-congruent action remains.

Hagan & Smail (1997b) propose that it is futile and even cruel to expect psychological change in patients without providing them with the resources to bring about that change. The agreement with individuals of achievable goals is one approach: however, the concept of power mapping (Hagan & Smail, 1997a) may provide a possible paradigm in which to work. This is considered further in the suggestions for research, below. Ryle and Kerr (2002) note that power mapping can be integrated with Cognitive Analytic Therapy (CAT), which is increasingly used within forensic services and with people who have experienced complex trauma. There is a promising, albeit limited, evidence base for CAT (Calvert & Kellett, 2014): however, as a relational therapy, it might be of particular use in addressing some of the issues raised by Mann et al. (2014).

Our results also suggest that the question of trauma-informed treatment is pertinent. While some of the participants will have had previous trauma-informed psychotherapy, this cannot

be guaranteed at all secure units. Practitioners with an informed understanding of trauma therapy, such as clinical psychologists, might therefore usefully work with other professionals who are adopting a recovery approach, to provide training, support and direct input. This includes an awareness of the traumatic impact of a person's own historic behaviour, and the possibility of compassion-focused work in response (Witvliet et al., 2010). Access to psychological therapy as part of a discharge care plan would be optimal for many patients (Palermo, 2014): while this increases pressure on services and would require additional investment in specialist clinical psychology, it might – as in so many areas – bring longer-term gain (Wells, 2010).

Finally, peer support may be a valuable model for services to explore, either on an individual or group basis (Gilmartin, 1997). Participants spoke of the value of support from peers, and further formalised support is being explored at the secure unit where the research was based. Paid peer-support workers – people with lived experience as forensic service users – could be a valuable addition to any community team, though Slade et al. (2014) caution that services must value such workers equally with other staff, and at a more fundamental level their offence histories may act as a barrier to employment in this area. Mann et al. (2014) describe a weekly group for forensic patients approaching discharge or already discharged, allowing for the regular discussion of practical and emotional challenges, and the development of supportive relationships and friendships. If power differentials can be suitably managed – Line, Marsh, & Cooke (2014) describe a practical example of co-produced group working – then such groups have the additional advantage of offering re-empowerment at a small collective level (Rose, 2014).

#### 4.5. Directions for further research

All of the areas outlined above lend themselves to further practice-based research by clinical psychologists and other disciplines. Small- or single-N studies reporting different interventions would be a valuable addition to the wider evidence base: something particularly important where the power-mapping method of Hagan and Smail (1997a) is concerned. It is an approach more associated with community psychology than clinical psychology, and there is no obvious therapeutic evidence base: however, integration with CAT offers scope for small-scale clinical trials. Power mapping provides a graphical way in which people can make sense of their situation using not just individual but environmental, social and political factors, and to explore different avenues by which they might obtain empowerment in keeping with their personal values. Harper and Speed (2012) suggest that



the approach may be used by clinicians as a way of identifying structural facilitators of recovery; within forensic services, this could feasibly allow for the exploration of opportunities while acknowledging the impact of legal restrictions.

In keeping with the focus of this study, there is likely to be value in further qualitative research asking for whom the recovery approach works, and by what processes. Jamieson, Taylor, and Gibson (2006) provide an emergent grounded theory of the transition from secure care to independent living based on interviews with clinical staff. A grounded-theory design using interviews with patients could be used to explore the processes of recovery in more detail, and would be a fruitful follow-up to the current project provided it could be carried out on a large enough scale to meet the methodological criteria (Smith et al., 2009). This is an area where Scottish clinical psychology training programmes and the Scottish Forensic Network may be able to facilitate a multi-site, multi-researcher study.

Discussion of context, power and exclusion places the focus as much on systemic and societal issues as on individual intervention. Davidson & Roe (2007) argue that there is a lack of understanding of mental illness generally in societies, and propose that programmes of community education might improve this. Wolff, Pathare, Craig, and Leff (1996) studied the effect of a public education campaign on community attitudes to people with mental illness, and observed a lessening of fearful and rejecting attitudes: they observed that this appeared to be mediated by increased social contact, although no path analysis was carried out. There appears to have been little further research in this vein in the intervening decades. Jamieson et al. (2006) suggest that every effort must be made to establish a more critical understanding of what ‘community’ actually means in community care, and qualitative research with those involved both directly and indirectly (e.g. neighbours) with people discharged from secure care would be a valuable approach.

Co-production of research between clinicians, academics and service users is increasingly a focus for services (McKirdy, 2015), and interested service users might be encouraged to become directly involved in the design and implementation of any such work. Service-user involvement at the development and design stage of research in general can bring a number of benefits, such as different perspectives on priorities and outcomes under consideration, and further empowerment and participation of people outwith traditional professional networks (McKirdy, 2015; MacInnes, Beer, Keeble, Rees, & Reid, 2011). Given the difficulties that exist around operationalisation, such input might be particularly useful in

recovery-related research: it would also be in keeping with the service-user-led fundamentals of the recovery approach, provided a balance of views could be maintained. Service-user involvement in forensic mental-health research has traditionally been limited. MacInnes et al. (2011) argue that collaborative co-production in such settings is both feasible and desirable, though they observe that care must be taken to ensure meaningful rather than tokenistic involvement, and that clarity of roles and expectations is an important concern, as is confidentiality.

#### 4.6. Limitations of, and reflections on, the present study

Philosophically, the lack of service-user input into the design and implementation of this research is its biggest flaw. The balance of power remains with the researchers: while qualitative research allows for marginalised voices to be heard, it was nevertheless a professional researcher who analysed and presented those voices in this study, and a ‘them and us’ distinction remains (Barnao et al., 2010). Consultation with representative service users at the planning stage might have allowed for different perspectives on the topic guide and on the secondary research questions. Respondent validation of results (Malterud, 2001), for example via a representative focus group, was not achieved in the present study, but would be another way of involving service users in the research process, and can hopefully be included in future research. As with all focus groups, care would need to be taken to ensure a balanced range of views: given that recruitment to the present study was not straightforward, this may be a challenge. It would also be important to ensure that forensic service users did not feel coerced into discussing issues about which they did not want to talk, particularly in a group setting.

Recruitment to the study was not straightforward, and we are profoundly grateful to the eight people who agreed to take part. Ideally within an IPA study, information would be included about each participant to illustrate more clearly their individual contexts (Smith et al., 2009). In this research, however, issues of anonymity were very much to the fore, and the decision was made to minimise detail that might identify anyone. While the narratives and opinions of those who took part cannot be taken as representative of any wider population, people articulated a range of experiences and opinions. Nevertheless, the narratives of those who declined an invitation to participate, or who were not able to take part, might have been of equal value and may have provided different perspectives. All medium-secure units are not the same, and certain facets of the setting in which this research took place – how step-down

to lower security is facilitated; the therapeutic milieu – will have affected the findings to some extent.

The attempt to explore participants' values as part of a qualitative study looking primarily at barriers to recovery was ambitious, and not entirely successful. Little was learned, for example, about congruence between participants' values and what they believed to be the values of wider society. This may be because participants found these more abstract questions less interesting or engaging than the more personal discussion about their own recovery which preceded them: as noted above, service-user input into the topic guide might have been one way of addressing this. A mixed-design approach in which values were examined using a measure such as the Valued Living Questionnaire (Wilson et al., 2011) may also have allowed for more clearly delineated data. More generally, the focus of the research on barriers to recovery is perhaps indicative of a traditionally pessimistic approach to work in the forensic and offence-focused areas (Farrall, Lightowler, McNeill, & Maruna, 2013): future IPA work might therefore explore facilitators of recovery.

Further contextual reflection on this study, in keeping with the epistemological principles of IPA, is provided in a short accompanying article (Stuart, in preparation).

#### 4.7. Conclusion

Despite its flaws, we believe that this is a valuable study which begins to explore the hitherto neglected area of recovery after discharge from forensic secure care. Difficulties have been shown to be a key but overlooked process within recovery (Stuart et al., in preparation): for former forensic inpatients, difficulties may be magnified, and our research suggested various barriers, both cognitive and contextual. Davidson, O'Connell, Tondora, Styron and Kangas (2006) raise the important question of whether 'recovery' is a term most service users would choose to use: for the majority of our participants, there appeared to be a discrepancy between the optimistic tenets of the recovery approach and their lived experience. A focus on intrinsic reinforcement – on values – might therefore be of clinical benefit. Pragmatism is vital, but further change remains possible, both individually and systemically (Harper & Speed, 2012; Slade et al., 2014). While it is unlikely that any forensic service adopting a recovery approach would do so naively (Drennan & Aldred, 2012a), we hope this research will inspire further research and discussion.

## References

- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11–23.
- Arenella, J. (2015). Challenges for the recovery movement in the US: Will its light reach the darkest corners? *Clinical Psychology Forum* (268), 7–9.
- Barnao, M., Robertson, P., & Ward, T. (2010). Good Lives Model Applied to a Forensic Population. *Psychiatry, Psychology and Law*, 17(2), 202–217.
- Barnao, M., Ward, T., & Casey, S. (2014). Looking Beyond the Illness: Forensic Service Users' Perceptions of Rehabilitation. *Journal of Interpersonal Violence*. Advance online publication. doi: 10.1177/0886260514539764
- Beresford, P. (2015). From “recovery” to reclaiming madness. *Clinical Psychology Forum* (268), 16–20.
- Browne, G. (2006). Outcome measures: Do they fit with a recovery model? *Australian & New Zealand Journal of Mental Health Nursing*, 15(2), 153–154.
- Burgess, S. L. H. (2011). *Exploring the experience of community adjustment following discharge from a low secure forensic unit*. Doctoral thesis, University of Leeds. Retrieved June 9, 2013, from <http://etheses.whiterose.ac.uk/1741/>
- Calvert, R., & Kellett, S. (2014). Cognitive analytic therapy: A review of the outcome evidence base for treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, 87(3), 253–277.
- Carr, A. (1999). *The handbook of child and adolescent clinical psychology: A contextual approach*. London: Routledge.
- Chandley, M., & Rouski, M. (2014). Recovery, turning points and forensics: views from the ward in an English high secure facility. *Mental Health and Social Inclusion*, 18(2), 83–91.
- Chenail, R. J. (2011). Learning to appraise the quality of qualitative research articles: A contextualized learning object for constructing knowledge. *The Qualitative Report*, 16(1), 236–248.
- Coffey, M. (2012a). Negotiating identity transition when leaving forensic hospitals. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness & Medicine*, 16(5), 489–506.
- Coffey, M. (2012b). A risk worth taking? Value differences and alternative risk constructions in accounts given by patients and their community workers following conditional discharge from forensic mental health services. *Health, Risk & Society*, 14(5), 465–482.
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training*, 41(4), 412–425.
- Cozzarelli, C., Karafa, J. A., Collins, N. L., & Tagler, M. J. (2003). Stability and change in adult attachment styles: associations with personal vulnerabilities, life events and global construals of self and others. *Journal of Social and Clinical Psychology*, 22(3), 315–346.
- Crichton, J. H., Darjee, R., McCall-Smith, A., & Chiswick, D. (2001). Mental Health (Public Safety and Appeals) (Scotland) Act 1999: detention of untreatable patients with psychopathic disorder. *The Journal of Forensic Psychiatry*, 12(3), 647–661.
- Crisford, H., Dare, H., & Evangeli, M. (2008). Offence-related posttraumatic stress disorder (PTSD) symptomatology and guilt in mentally disordered violent and sexual offenders. *The Journal of Forensic Psychiatry & Psychology*, 19(1), 86–107.
- Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, 57(5), 640–645.
- Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16(4), 459–470.
- Davies, S., Clarke, M., Hollin, C., & Duggan, C. (2007). Long-term outcomes after discharge from medium secure care: a cause for concern. *The British Journal of Psychiatry*, 191(1), 70–74.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11–19.
- Division of Clinical Psychology (DCP) (2014). *Understanding psychosis and schizophrenia*. Leicester: British Psychological Society.
- Dorkins, E., & Adshead, G. (2011). Working with offenders: challenges to the recovery agenda. *Advances in Psychiatric Treatment*, 17(3), 178–187.

- Drennan, G., & Aldred, D. (2012a). Recovery in forensic mental health settings: from alienation to integration. In G. Drennan & D. Aldred (Eds.), *Secure recovery: Approaches to recovery in forensic mental health settings* (pp. 1–22). Oxon: Routledge.
- Drennan, G., & Aldred, D. (Eds.). (2012b). *Secure recovery: Approaches to recovery in forensic mental health settings*. Oxon: Routledge.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215–229.
- Farrall, S., Lightowler, C., McNeill, F., & Maruna, S. (2013). *Discovering desistance: Provocative propositions for reconfiguring social justice*. Retrieved from <http://blogs.iriss.org.uk/discoveringdesistance/files/2013/08/DesKE-Propositions.pdf>
- Gilmartin, R. M. (1997). Personal narrative and the social reconstruction of the lives of former psychiatric patients. *J.Soc. & Soc. Welfare*, 24, 77–102.
- Gray, N. S., Carman, N. G., Rogers, P., MacCulloch, M. J., Hayward, P., & Snowden, R. J. (2003). Post-traumatic stress disorder caused in mentally disordered offenders by the committing of a serious violent or sexual offence. *The Journal of Forensic Psychiatry & Psychology*, 14(1), 27–43.
- Green, T., Batson, A., & Gudjonsson, G. (2011). The development and initial validation of a service-user led measure for recovery of mentally disordered offenders. *Journal of Forensic Psychiatry & Psychology*, 22(2), 252–265.
- Gudjonsson, G. H., Savona, C. S. V., Green, T., & Terry, R. (2011). The recovery approach to the care of mentally disordered patients. Does it predict treatment engagement and positive social behaviour beyond quality of life? *Personality and Individual Differences*, 51(8), 899–903.
- Gudjonsson, G. H., Webster, G., & Green, T. (2010). The recovery approach to care in psychiatric services: staff attitudes before and after training. *The Psychiatrist*, 34(8), 326–329.
- Hagan, T., & Smail, D. (1997a). Power-mapping—I. Background and basic methodology. *Journal of Community & Applied Social Psychology*, 7(4), 257–267.
- Hagan, T., & Smail, D. (1997b). Power-mapping—II. Practical application: the example of child sexual abuse. *Journal of Community & Applied Social Psychology*, 7(4), 269–284.
- Harper, D., & Speed, E. (2012). Uncovering recovery: the resistible rise of recovery and resilience. *Studies in Social Justice*, 6(1), 9–26.
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and Commitment Therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, 44(1), 1–25.
- Hayes, S. C., & Pierson, H. (2005). Acceptance and commitment therapy. In A. Freeman, S. H. Felgoise, C. M. Nezu, A. M. Nezu, & M. A. Reinecke (Eds.), *Encyclopedia of cognitive behavior therapy* (pp. 1–4). New York: Springer.
- Hellawell, S. J., & Brewin, C. R. (2004). A comparison of flashbacks and ordinary autobiographical memories of trauma: content and language. *Behaviour Research and Therapy*, 42(1), 1–12.
- Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377–391.
- Hirschi, T. (2002). *Causes of delinquency*. New Brunswick, N.J.: Transaction.
- Howells, K. (2010). The “third wave” of cognitive-behavioural therapy and forensic practice. *Criminal Behaviour and Mental Health*, 20(4), 251–256.
- Jacques, J., Spencer, S., & Gilluley, P. (2010). Long-term care needs in male medium security. *The British Journal of Forensic Practice*, 12(3), 37–44.
- Jamieson, L., Taylor, P. J., & Gibson, B. (2006). From pathological dependence to healthy independence: An emergent grounded theory of facilitating independent living. *The Grounded Theory Review*, 6(1), 79–108.
- Kabat-Zinn, J. (2003). Mindfulness-Based Interventions in Context: Past, Present, and Future. *Clinical Psychology: Science and Practice*, 10(2), 144–156.
- Laithwaite, H., & Gumley, A. (2007). Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting. *Clinical Psychology & Psychotherapy*, 14(4), 302–316.
- Langan, J. (2010). Challenging assumptions about risk factors and the role of screening for violence risk in the field of mental health. *Health, Risk & Society*, 12(2), 85–100.

- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry*, 199(6), 445–452.
- Line, R., Marsh, L., & Cooke, S. (2014). Steps beyond: Reflections on a post-therapy group developed in partnership. *Clinical Psychology Forum*, (260), 25–28.
- Lundgren, T., Luoma, J. B., Dahl, J., Strosahl, K., & Melin, L. (2012). The Bull's-Eye Values Survey: A Psychometric Evaluation. *Cognitive and Behavioral Practice*, 19, 518–526.
- MacInnes, D., Beer, D., Keeble, P., Rees, D., & Reid, L. (2011). Service-user involvement in forensic mental health care research: Areas to consider when developing a collaborative study. *Journal of Mental Health*, 20(5), 464–472.
- Maden, A., Rutter, S., McClintock, T., Friendship, C., & Gunn, J. (1999). Outcome of admission to a medium secure psychiatric unit. I: Short-and long-term outcome. *The British Journal of Psychiatry*, 175(4), 313–316.
- Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358(9280), 483–488.
- Mann, B., Matias, E., & Allen, J. (2014). Recovery in forensic services: Facing the challenge. *Advances in Psychiatric Treatment*, 20(2), 125–131.
- Maruna, S. (2001). Making good: How ex-convicts reform and reclaim their lives. *Washington, D.C.: American Psychological Association*.
- McKirdy, J. (2015). Patient and public involvement in research. *DCP-S Review* (11), 15–17.
- Mezey, G. C., Kavuma, M., Turton, P., Demetriou, A., & Wright, C. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *Journal of Forensic Psychiatry and Psychology*, 21(5), 683–696.
- Mezey, G., & Eastman, N. (2009). Choice and social inclusion in forensic psychiatry: acknowledging mixed messages and double think. *The Journal of Forensic Psychiatry & Psychology*, 20(4), 503–508.
- Monger, B., Hardie, S. M., Ion, R., Cumming, J., & Henderson, N. (2013). The Individual Recovery Outcomes Counter: preliminary validation of a personal recovery measure. *The Psychiatrist*, 37(7), 221–227.
- Mullen, P. E. (2000). Forensic mental health. *The British Journal of Psychiatry*, 176(4), 307–311.
- Nijdam-Jones, A., Livingston, J. D., Verdun-Jones, S., & Brink, J. (2014). Using social bonding theory to examine “recovery” in a forensic mental health hospital: A qualitative study. *Criminal Behaviour and Mental Health*. Advance online publication. doi:10.1002/cbm.1918
- O’Sullivan, M., Boulter, S., & Black, G. (2013). Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study. *Journal of Forensic Psychiatry & Psychology*, 24(3), 1–18.
- Paden, S. (2010). *Recovery and forensics – a tricky balancing act*. Retrieved from Scottish Recovery Network website: <http://www.scottishrecovery.net/Submitted-thoughts-and-stories/recovery-and-forensicsa-tricky-balancing-act.html>
- Palermo, G. B. (2014). The Mentally Ill Offender: Failed Reintegration and Recidivism. *International Journal of Offender Therapy and Comparative Criminology*, 58(7), 763–764.
- Polit, D. F., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, 47(11), 1451–1458.
- Plumb, J. C., Stewart, I., Dahl, J., & Lundgren, T. (2009). In search of meaning: Values in modern clinical behavior analysis. *The Behavior Analyst*, 32(1), 85.
- Roberts, G. (2011). “Forensic service user”: transitional identity or life sentence? *Advances in Psychiatric Treatment*, 17(3), 188–190.
- Roberts, G., & Boardman, J. (2013). Understanding “recovery.” *Advances in Psychiatric Treatment*, 19(6), 400–409.
- Robertson, P., Barnao, M., & Ward, T. (2011). Rehabilitation frameworks in forensic mental health. *Aggression and Violent Behavior*, 16(6), 472–484.
- Rose, D. (2014). The mainstreaming of recovery. *Journal of Mental Health*, 23(5), 217–218.
- Roychowdhury, A. (2011). Bridging the gap between risk and recovery: a human needs approach. *The Psychiatrist*, 35(2), 68–73.
- Ryle, A., & Kerr, I. B. (2002). *Introducing cognitive analytic therapy: Principles and practice*. Chichester: John Wiley & Sons.

- Schwartz, S. (2012). Toward refining the theory of basic human values. In S. Salzborn, E. Davidov, and J. Reinecke (Eds.) *Methods, theories, and empirical applications in the social sciences* (pp. 39–46). New York: Springer.
- Schwartz, S. H. (2011). Studying values: Personal adventure, future directions. *Journal of Cross-Cultural Psychology*, 42(2), 307–319.
- Schwartz, S. H., & Bardi, A. (2001). Value Hierarchies Across Cultures Taking a Similarities Perspective. *Journal of Cross-Cultural Psychology*, 32(3), 268–290.
- Scottish Government (2012). *Mental Health Strategy for Scotland: 2012–2015*. Retrieved March 9, 2015, from <http://www.gov.scot/Publications/2012/08/9714>
- Scottish Office (1999). *Health, social work and related services for mentally disordered offenders in Scotland*. Edinburgh: HMSO.
- Scottish Parliament (2013). *Social Care (Self-directed Support) (Scotland) Act 2013*. Edinburgh and Norwich: The Stationery Office.
- Silverstein, S. M., & Bellack, A. S. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review*, 28(7), 1108–1124.
- Simpson, A. I. F., & Penney, S. R. (2011). The recovery paradigm in forensic mental health services. *Criminal Behaviour and Mental Health*, 21(5), 299–306.
- Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., ... Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1), 12–20.
- Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39–54.
- Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5(1), 9–27.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Smith, J., & Garcia, V. (2012). Recovering personhood: Using recovery principles on a long-stay medium secure ward. In G. Drennan & D. Aldred (Eds.), *Secure recovery: Approaches to recovery in forensic mental health settings* (pp. 103–114). Oxon: Routledge.
- Smith-Merry, J., Freeman, R., & Sturdy, S. (2011). Implementing recovery: An analysis of the key technologies in Scotland. *International Journal of Mental Health Systems*, 5(11). Online. Retrieved from <http://www.ijmhs.com/content/5/1/11>
- Thornton, T., & Lucas, P. (2011). On the very idea of a recovery model for mental health. *Journal of Medical Ethics*, 37(1), 24–28.
- Turton, P., Demetriou, A., Boland, W., Gillard, S., Kavuma, M., Mezey, G., ... Wright, C. (2011). One size fits all: or horses for courses? Recovery-based care in specialist mental health services. *Social Psychiatry and Psychiatric Epidemiology*, 46(2), 127–136.
- Watkins, E. R. (2008). Constructive and unconstructive repetitive thought. *Psychological Bulletin*, 134(2), 163–206.
- Wells, T. (2010). *Applied psychologists and psychology in NHS Scotland*. Scottish Government.
- Wenzlaff, R. M., & Wegner, D. M. (2000). Thought Suppression. *Annual Review of Psychology*, 51(1), 59–91.
- Wilson, A. E., & Ross, M. (2001). From chump to champ: People's appraisals of their earlier and present selves. *Journal of Personality and Social Psychology*, 80(4), 572–584.
- Wilson, K. G., Sandoz, E. K., Kitchens, J., & Roberts, M. (2011). The Valued Living Questionnaire: Defining and measuring valued action within a behavioral framework. *The Psychological Record*, 60(2), 4.
- Witvliet, C. vanOyen, Knoll, R. W., Hinman, N. G., & DeYoung, P. A. (2010). Compassion-focused reappraisal, benefit-focused reappraisal, and rumination after an interpersonal offense: Emotion-regulation implications for subjective emotion, linguistic responses, and physiology. *The Journal of Positive Psychology*, 5(3), 226–242.
- Woldgabreal, Y., Day, A., & Ward, T. (2014). The community-based supervision of offenders from a positive psychology perspective. *Aggression and Violent Behavior*, 19(1), 32–41.
- Wolff, G., Pathare, S., Craig, T., & Leff, J. (1996). Public education for community care: a new approach. *British Journal of Psychiatry*, (168), 441–447.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215–228.

## Chapter 4

### Extended method

#### Aim

This study aimed to understand the experiences of recovery in a sample of people discharged from forensic secure care, and in particular to explore the barriers to recovery that they perceived. Secondary to this, the lead researcher hoped to consider participants' values, the extent to which they perceived these as important to recovery, and if possible the extent to which they saw their personal values as congruent with the values of wider society.

#### Design

Because the aim was to understand participants' lived experience, the study was designed explicitly to use interpretative phenomenological analysis (IPA): a method created and developed by psychologists, to examine how individuals make sense of experience (Smith, Flowers & Larkin, 2009). Epistemologically, IPA is inductive and exploratory, as opposed to the more deductive and explanatory positivist approaches that characterise much clinical-psychology research (Elliott, Fischer & Rennie, 1999). Furthermore, unlike the qualitative method of Grounded Theory, IPA does not seek to develop an explanation of the processes involved in an experience: rather, it aims to capture meaning and common features (Starks & Trinidad, 2007). While much psychological research tests hypotheses at a large-group or even population level, IPA is focused on individuals in context and does not seek to produce widely generalisable claims – although credible IPA may nevertheless allow for a degree of generalisation (Smith et al., 2009). This idiographic approach means that IPA is well-suited to exploration of the experiences of a small group with a core context in common: in this case having been inpatients in the same medium-secure unit.

#### IPA: Further considerations

IPA is idiographic – it is concerned with the particular rather than the general – and phenomenological, in that it involves the philosophical study of experience, based on interpretation of individual subjectivity rather than an attempt to establish an objective truth (Brocki & Wearden, 2006; Smith et al., 2009). It is therefore a postmodern approach to analysis, in which different interpretations of complex phenomena can be constructed and reconstructed – by analysts and readers alike – in order to build an increasingly comprehensive understanding, but not one that would necessarily claim to be definitive (Malterud, 2001). For the analyst, interpretation involves an iterative process of hermeneutics, or interpretation and meaning-making, and within IPA the process is usually



described as a double hermeneutic. In short, this means that the participant is using verbal processes to try to make sense of their experience (first-order meaning-making), while the researcher is trying to make sense of the participant making sense of their experience (second-order meaning-making) (Smith, 2004; Smith et al., 2009).

IPA research is usually, though not always, carried out via direct participant interview: this was the approach used in the present study. A semi-structured interview schedule was constructed by SRS, the lead author (Appendix 5), incorporating questions about recovery and values as guided by the research focus. Smith et al. (2009) advise that questions should be as open as possible around the core phenomena to be explored, and suggest that the more confident the researcher, the less structured an interview might be. SRS had considerable experience of interviewing adults in both clinical and non-clinical settings, and utilised the schedule as a prompt rather than as a strict template to follow.

In terms of an appropriate sample size, the research was guided by the maxim of Smith et al. (2009): that IPA is a qualitative process in which quality is paramount, where the outcome is a detailed account of individual experience rather than a broad set of nomothetic themes. For this reason, IPA research tends towards small sample sizes. Starks and Trinidad (2007) observe that the unit of analysis in IPA is the experience being studied; given that a single interview with one individual can generate a huge number of concepts pertaining to that experience, they suggest that a large sample size is not necessary to achieve high-quality data. Hefferon and Gil-Rodriguez (2011) note that the dominant quantitative paradigm in academic research can lead to qualitative researchers feeling a sense of pressure to inflate sample sizes – an endeavour of uncertain worth given the profoundly different philosophical and epistemological foundations of the two approaches (Elliott et al., 1999). Smith et al. (2009) suggest a sample size of between four and ten interviews for professional-doctorate research such as this study, and caution against viewing higher numbers within this range as inherently superior. Guided by his academic supervisor, the author EQ, SRS approached recruitment with the expectation that a sample of seven people might provide a rich data set.

### Participants and recruitment

Participants were recruited via the forensic community mental-health team (FCMHT) at a single medium-secure unit (MSU) between June 2014 and March 2015. All participants had regular contact with a psychiatric nurse from the FCMHT and were under the care of a responsible medical officer (RMO), a consultant psychiatrist at the MSU. At the start of the

recruitment process, the researcher met with FCMHT staff to discuss potential participants, a purposive sampling approach in keeping with the principles of IPA (Smith et al., 2009). Meetings were subsequently held with FCMHT staff to discuss progress. Participants had to be 18 or over, able and willing to give informed consent to participate, currently resident in the community, and not currently experiencing acute symptoms of a severe mental illness. Not all participants under the FCMHT's care were deemed suitable – for instance because staff had concerns about their mental health at the time – and the researcher took guidance from the team about who might be included.

Once potential participants were identified, the researcher obtained written assent from their RMO to establish that each person had capacity to give free and informed consent about participation. The initial approach to potential participants was made by FCMHT staff during routine contact. They were given basic verbal information about the project and asked if they might like to take part; if they expressed interest, they were provided by the FCMHT with a printed, plain-language Participant Information Sheet (Appendix 6). They were to be given a minimum of 24 hours to read this before the FCMHT asked whether they wished to proceed; in fact, all were given at least a week. If they wished to take part, the researcher either contacted them directly to arrange a convenient time to meet, or arranged this through the FCMHT. Interviews took place either at an NHS outpatient clinic or at the participant's home, depending on their preference.

Recruitment was a lengthy and challenging process. In total, eight people agreed to participate and completed an interview with SRS, of whom five were male and three female, as described in the journal article. As also explained in the journal article, detail about the participants has been kept to a minimum throughout the thesis in order to preserve the anonymity of a sample within a very small population.

## **Procedure**

### Data collection

Immediately prior to interview, participants completed a consent form (Appendix 7). All participants were interviewed once. The interview schedule (Appendix 5) was constructed some months prior to the interviews being carried out: while it served as a topic guide, it does not reflect the open-ended, reflective and conversational way in which interviews were in fact conducted. Interviews were recorded using an encrypted, password-protected digital

recording device, and transcribed verbatim by SRS. Interviews ranged from 13 minutes to 68 minutes, with a mean length of 36 minutes.

### Data analysis

Transcripts were analysed by the researcher based on the IPA process recommended by Smith et al. (2009) for a larger sample ( $N > 6$ ). This consisted of six steps:

- 1. Reading and re-reading transcripts.** This involved immersive engagement with the participants' narratives, highlighting possibly salient aspects.
- 2. Initial noting.** This consisted of a line-by-line commentary on each transcript, including detailed observations on descriptions and the use of language, and an interrogative approach to exploring concepts and possible meanings for the participant.
- 3. Developing emergent themes at case level.** This step involved managing and reducing the detailed initial notes into concise salient observations, and starting to consider how these emergent themes might begin to connect with each other, for example by identifying commonalities, distinctions and patterns.
- 4. Moving to the next case,** and repeating steps 1-3 for each participant narrative.
- 5. Searching for connections between emergent themes.** The within-case analysis begun in step 3 was continued, with simultaneous cross-case analysis. Themes across cases were further grouped, distinguished and refined, using processes including abstraction, consumption and contextualisation (Smith et al., 2009).
- 6. Development of final themes and superordinate themes for the entire sample.**

An example page of transcript is included in Appendix 10, giving an indication of steps 2, 3 and 5.

Computer software allows a researcher to organise and interact with qualitative data, although it does not assist with the analytic process itself (Malterud, 2001). Textual commentary was facilitated using Microsoft Word. Steps 5 and 6 were further assisted by the use of Microsoft Excel: emergent themes and supporting textual extracts were assigned to spreadsheet cells and manually organised into clusters and columns using the basic drag-and-drop functionality. This is a promising method of handling thematic data using software readily available to most researchers and clinicians, and SRS intends to explore and refine this in future research.

### Quality and credibility

Smith (2011) describes a guide for evaluating IPA research, in which he suggests that an acceptable study needs to be:

- Phenomenological, hermeneutic and idiographic;
- Transparent, i.e. so the reader can understand what was done;
- Coherent, plausible and interesting;
- Demonstrative of sufficient evidence for each theme.

The researcher adopted these suggestions throughout this project. Nevertheless, applying quality criteria by Smith (2011) to a research method that is largely the creation of the same author could be viewed as a little circular, and other criteria exist to offer a more general evaluation of qualitative research. While it has been argued that quantitative concepts such as validity and reliability can equally apply to qualitative research (Poortman & Schildkamp, 2012), this argument overlooks the epistemological differences between qualitative and quantitative research as outlined above. For the purposes of this study, the researcher utilised quality guidance by Elliott et al. (1999), Chenail (2011) and Yardley (2000). The last of these proposes four general characteristics of good qualitative research, which are considered briefly below.

#### 1. Sensitivity to context

A key aspect of IPA is the awareness that research does not take place in a vacuum. The interpretative process is a dynamic one in which both researcher and participants play a key part in the construction of meaning (Brocki & Wearden, 2006) amid a wider and sometimes overlooked social and political context (Yardley, 2000). The concept of bracketing – of setting to one side one's preconceptions – was proposed by Husserl in the first part of the 20th century as a method of achieving a decontextualised phenomenological inquiry; however, contemporary researchers, informed by developments in cognitive psychology, recognise that this is a process which can never be truly achieved, and that the researcher, by dint of being human, will always bring some element of potential bias to the process (Smith et al., 2009). IPA researchers are therefore encouraged to reflect upon their role in the process: upon dynamic questions of the relationship between researcher and participants, especially concerning power differentials (Yardley, 2000), and upon to what extent their preconceptions and motivations may have impacted upon the entire piece of research from inception to completion (Brocki & Wearden, 2006; Reid, Flowers, & Larkin, 2005). To this end, the lead researcher kept a reflective journal throughout the study (Starks & Trinidad,

2007) and has produced a short article considering his motivations and possible biases in the Scottish and UK sociopolitical context (Stuart, in preparation).

## 2. Commitment and rigour

The second of the characteristics outlined by Yardley (2000) largely concern thoroughness of research. Commitment to the prolonged and time-consuming nature of IPA, and a rigorous approach to carrying it out, can arguably be measured in the quality of the finished work: it should be an in-depth analytic exploration of participants' experience demonstrating informed theoretical understanding and consideration, rather than a summary more akin to thematic analysis (Braun & Clarke, 2006). A rigorous IPA analysis also involves the use of wider support from supervisors or other researchers.

## 3. Transparency and coherence

These characteristics refer to the clarity by which the research process is described and the analysis presented, and to the congruence between the research question and the analytical approach adopted. In terms of coherence, the researcher believes that the preceding sections demonstrate the suitability of IPA as a method of inquiry in this instance: however, it should be noted that this was a decision made after consideration of different approaches, and lengthy discussion with academic and clinical supervisors. The detailed description of the processes involved demonstrates transparency of method and analysis; further transparency is provided via the aforementioned reflective article.

Transparency also implies trustworthiness (Golafshani, 2003) and auditability: the extent to which processes could be repeated, even if the analysis were to be different (Dixon-Woods, Shaw, Agarwal, & Smith, 2004). As noted, the researcher kept a reflective journal and has also filed all non-confidential correspondence, minutes of meetings and e-mail discussions by date, in a format which can be easily accessed for purposes of audit. With the approval of his supervisors, he is willing to discuss all such non-confidential information with appropriate interested parties. In the interests of transparency, four annotated transcripts were selected via computerised randomisation and reviewed by the author EQ. To further establish credibility, the analysis and development of themes from the participant transcripts was discussed more generally with EQ, who offered expert advice throughout the process (Elliott et al., 1999).

#### **4. Impact and importance**

These are the final characteristics outlined by Yardley (2000). The researcher believes that this project is a useful addition to the corpus of research about recovery processes in general, and the journeys of former forensic inpatients in particular. As outlined in the Introduction, this is an area in which little research currently exists. The positive response of participants and MSU staff has been cheering, and at least one of the interviewees has expressed interest in helping to disseminate any findings through service-user networks. The lead researcher is keen to pursue this in parallel to traditional academic methods of publication.

Ultimately, the aim of the written journal article was to provide a coherent explanation of what the project involved; of the contexts in and against which it took place; of the final interpretation of data by theme; and of why the endeavour might be important. In this way, each of the criteria outlined by Yardley (2000) has been considered, and hopefully met.

#### **Ethical considerations**

The study was approved by the NHS South of Scotland Research Ethics Committee (REC) 01 and by the Research and Development (R&D) department of the health board in which the MSU was situated (Appendix 8). It was also approved by MSU management. After the project had begun, an amendment was submitted to the REC and R&D department to allow participants to be interviewed in their own homes: this was also approved.

Participation was voluntary, and the researcher agreed with the FCMHT that no pressure would be put on anyone to participate. It was made clear to participants and potential participants that they could withdraw from the process at any time without giving a reason, including mid-interview. Recordings were stored in a highly secure computer environment at the MSU, in line with local policies and the Data Protection Act of 1998, with passwords known only to authors SRS and LT, the clinical supervisor. No patient-identifiable data were included in the transcripts.

Since the purpose of the research was to explore participants' experiences post-discharge, SRS did not wish to engage them in discussion about their index offence or mental-health history. However, he recognised that, in order to have an accurate understanding of the length of time they had spent at the clinic, it would be useful to have access to the electronic records held at the MSU concerning each participant. To this end he applied for and received Caldicott Guardian approval to access this data (Appendix 8); in addition, the consent form

explicitly asked each participant for their permission to access this information. One participant refused, and therefore none of their data were accessed.

One participant was someone with whom SRS had had short-term clinical contact 12 months previously, while on initial placement at the MSU. The FCMHT staff and the clinical supervisor felt that this person would be an appropriate interviewee, and the participant themselves was keen to take part. Following further discussion with the FCMHT, the clinical supervisor and the academic supervisor, it was agreed that the researcher's previous contact with this participant should not preclude them from taking part in the study. SRS was keenly aware that the additional contact could bias his analysis, and made particular effort to notice this and to adhere to the inductive, participant-led principles of IPA (Smith et al., 2009).

During the interview process, SRS adhered to local NHS lone-worker and safe-and-well guidelines to ensure personal safety. Subsequent to interview, he recorded a brief note of his contact with each participant on the MSU's electronic database, and informed both the RMO and the participant's GP that the interview had been completed. If any information of concern was provided by a participant, this was both logged on the MSU database and followed up verbally with the FCMHT. One participant stated during the course of the interview that they experienced suicidal thoughts. The researcher used his clinical skills to explore briefly whether there was any imminent risk (there was not); he then fed this information back to MSU staff as described. This allowed for an efficient method of information-sharing in the interests of patient safety.

## Chapter 5

### **Addressing the balance of evidence and power: personal reflections on research in recovery**

*This short paper<sup>2</sup> considers the context of the author's doctoral thesis, informed by the epistemological principles of interpretative phenomenological analysis. It proposes that professionals might listen more carefully, and in new ways, to service users' voices.*

For more than two years, a core element of my doctoral training in clinical psychology has been the production of a thesis exploring aspects of the recovery approach within mental-health services (the interested reader is directed to Roberts & Boardman, 2013, for a service-focused review of the recovery concept, and Harper & Speed, 2012, for a social-constructionist critical analysis). My own project has two major elements: a systematic review of qualitative literature pertaining to recovery processes, and a primary-research component exploring the barriers to recovery perceived by people discharged from forensic secure care. The primary research used interpretative phenomenological analysis (IPA; Smith et al., 2009), an essential aspect of which is that the researcher adopts a critical, reflexive stance to their own work. This brief paper fulfils two functions. First, it allows me to take that stance: to interrogate my primary research, and to acknowledge the biases I might have brought. Second, it allows for a consideration of the entire thesis in the context of issues pertinent to clinical psychology.

#### Reflecting critically on my research

My thesis began pragmatically. As is now the case for many doctoral trainees in Scotland, I was aligned to a specific discipline for part of my training (Wells, 2010): in my case forensic clinical psychology, something of which I had no experience. My research interests lay primarily in the interface between the social and the clinical: this appeared germane when I realised how little research there was exploring how people discharged from forensic secure care manage the transition to community living. At the medium-secure unit where I was based, the recovery approach had become part of the staff ethos, and this provided a rationale: how did people discharged into the community make sense of their own recovery? My academic supervisor noted that these were people whose voices were seldom heard, an observation which further fuelled my motivation. A secondary aspect of the research was to understand more about participants' values, something which stemmed from my growing

---

<sup>2</sup> Prepared in line with the publication guidelines for Clinical Psychology Forum. See Appendix 11. Word count, including references: 2444



interest in both Acceptance and Commitment Therapy (ACT; Hayes et al., 2013) and the Good Lives Model of offender rehabilitation (Barnao et al., 2010).

Methodologically, IPA, with its focus on the phenomenological and the hermeneutic, appeared apposite. What I wanted to explore was how participants conceptualised recovery; how they made sense of their experiences in light of that conceptualisation and their values; and what they personally perceived to be holding them back. I spent considerable time trying to decide whether a focus on barriers to recovery was the best approach: whether I should go into the research expecting there to be problems (as the small amount of existing literature suggested) and attempting to find out more about these, or whether I should focus more generally on what recovery meant to the participants. I opted for the former, as it appeared to provide a sharper focus for the project. With hindsight, I believe I should have chosen the latter, to allow for a more exploratory piece of work. My interviews with participants did involve both aspects, and I suspect that the final themes would not differ substantially had the focus of the work been more general. Philosophically, however, it would have involved less of an imposition of my own, negative expectations.

Why, then, did this research appeal to me? What motivated me to work with people whose voices were not generally heard? I cannot reflect on this without considering my own professional past. Before I started studying psychology at undergraduate level in 2007, I had worked for more than a decade as a newspaper sub-editor. It was only as I was leaving journalism that I began properly to consider the fact that only a very small number of voices – those considered by powerful editors to be in some way worthy – were privileged enough to be reported. Perhaps I was therefore hopeful that my research might be a small way of redressing that balance. Again, with hindsight, this appears a little naive. Through adopting a traditional, interview-based approach to qualitative research, and aiming to publish in a clinical journal, certain aspects of certain voices will be heard by certain people: something I believe is valuable, but which nevertheless consolidates my professional role as researcher. The double hermeneutic of IPA involves making sense of participants making sense of their experiences, but it is my making sense that has primacy. As a piece of pre-qualification research under the auspices of both a university and a health board, the project was subject to various practical constraints: nevertheless, co-production of research with service users is possible within a clinical-training paradigm (Neech, 2014) and I hope that it will be explored more frequently by future trainees.

Considering my primary research as a piece of IPA, I am aware that there has been a pressure – largely self-imposed – to produce a work that does not exist on purely phenomenological terms but fits a narrative of usefulness: ‘how is this clinically relevant’? In particular, discussion of values tended to take place towards the end of participant interviews, and there were times when this felt a little artificial: almost as if, having offered people the chance to talk about recovery on their own terms, I was then asking them to humour me by considering a specific psychological element that I had introduced. Harper (2013) cautions that many trainees approach the phenomenological method in a formulaic way, and that we sometimes allow external models or discourses to shape our research. I hope that this has not dominated my analysis – certainly, I would argue that none of my themes represents an imposition of a clinical concept – though it could be argued that what I have done is to turn the voices of service users into something predominantly useful for services. However, I also recognise that I produced this work while being paid by an NHS Scotland board to train as a clinical psychologist, and it is therefore reasonable of my employers, my examiners and anyone else reading the thesis to expect that it has some direct clinical relevance. Perhaps a more confident researcher would not feel the need to justify their work in such a way.

### What is ‘evidence’?

I have learned a lot about listening to the voices of people who use mental-health services, and a contextual issue becomes important here. Although it is not directly related to my research question, it has formed a backdrop to much of my training, and has informed and influenced my understanding of my thesis. This issue is the debate among psychologists and other professionals about how psychotic experiences can best be conceptualised (DCP, 2014), and the value of psychological therapies for psychosis, particularly Cognitive Behavioural Therapy, or CBTp (e.g. Hutton et al., 2013; Jauhar et al., 2014).

This argument has taken place not only in the traditional milieu of journal articles and professional publications, but on blogs (e.g. <http://www.thementalelf.net>) and on the social network Twitter (<http://twitter.com>). This is a hugely important development in that it opens up debate beyond the confines of academia, allowing everyone with an interest to become involved. However, as I discovered with a clumsily worded tweet during a complex Twitter exchange subsequent to the publication of the document by the DCP (2014), it is very easy unintentionally to reinforce the dominance of the academic and professional voice at the expense of other people’s. This was salutary. Watching the Twitter debate unfold during

2014, I began wondering to what extent the nature of what is accepted as ‘evidence’ marginalises people with lived experience. Robust nomothetic evidence – usually, but not always, quantitative – would be discussed on Twitter by professionals critical of CBTp; if individual people countered this with examples of their own valued experiences, the professional response would often be that anecdote is not evidence. For that person, however – and this is where IPA has so much potential – their subjective experience is a form of personal, phenomenological evidence. Certainly, it is a different kind of evidence, but then what constitutes ‘evidence’ per se?

At base, that is an epistemological question, and a researcher working in a broadly post-positivist paradigm might give a different answer to one using an interpretivist approach. However, the question is also driven by practicalities and priorities. NHS mental-health services, for example, require a broad understanding of what works and what might usefully be recommended for a majority of patients (e.g. the Matrix review of psychological therapies produced by NHS Education for Scotland, 2011), and a scientific approach that allows psychotherapeutic outcomes to be operationalised, quantified and compared is of great value here. Nonetheless, individuals may also have strong beliefs about what has worked – or not worked – for them, and to dismiss this as anecdotal risks not just invalidating their experiences but ignoring a source of data. An approach such as IPA allows such phenomenological data to be analysed and explored – and while Twitter, with its 140-character limit, may produce data that is too thin, social media and blogs still offer open-minded researchers a new environment in which to work.

The systematic-review chapter of my thesis considers only evidence published in peer-reviewed journals. However, I have witnessed rich, rewarding discussions among service users on social media about their experiences of recovery, and I suspect several of these people would welcome those experiences becoming a formalised part of research, informing a qualitative evidence base which provides another perspective on both outcomes and processes. Moreover, social-media-based research might allow them more easily to become co-producers if they wished, offering valuable and original perspectives on research questions and analysis. Rather than dismissing ‘anecdote’, then, we might more usefully ask: at what point does a collection of anecdotes become qualitative data that can be analysed? If we were to be particularly provocative, we might also ask not just ‘what constitutes evidence’ but ‘who gets to *decide* what constitutes evidence’? Should this be the preserve only of privileged, highly educated researchers with an in-depth understanding of specific

techniques (which may in themselves be contended: Trafimow & Marks, 2015) or can other voices answer that question too? This has become an increasingly dominant consideration for me as I have produced my thesis and progressed through my training.

### Politics and power

Another argument took place as I was working on my thesis: one which may not seem directly relevant to clinical psychology, but which involved a further consideration of privileged expression. This was the debate surrounding the Scottish independence referendum, which dominated Scottish – and briefly UK – politics during 2014. I found this galvanising and, as with the CBTP debate, deeply thought-provoking. Both traditional and social media carried increasingly fervent expressions of belief, and of all campaigners the same question could be asked: to what purpose do your voices speak? Is it to protect and consolidate your own power, or to ask critically what might happen if the balance was shifted? The debate, and my reaction to it, led to my questioning further my own research, and I recognised that many of my reasons for choosing this project – many of my reasons, in fact, for choosing clinical psychology – are rooted in my personal politics. These are firmly within the socialist tradition, but from an academic, bourgeois perspective, not lived experience of struggle. This highlighted once again the power differential within my thesis: should a piece of research in which themes of struggle are prominent be produced solely by an observer of struggle? Does this redress the power imbalance or perpetuate it? Nevertheless, if, as an empowered professional, my research sheds any light upon what it means for a human being to be marginalised and disempowered, I will consider it a success.

The dominant theme in all my reflections upon my thesis, then, is one of differential power. A harassed trainee clinical psychologist might not readily admit it, but we are in a rarefied position within the NHS, qualifying and entering the profession at what is a comparatively senior level among allied health professionals. Perhaps we should continually ask ourselves: how do we intend to use that power? My research has taught me to ask a question which I rarely, if ever, asked in my previous career: whom are we doing this work *for*? If the recovery approach is being used by services because it genuinely allows for collaborative, empowering work with individuals to achieve their valued outcomes, this is admirable – as long as those individuals are listened to, and their views are valued as much as those of professionals. At present, my thesis offers a flawed attempt to do this. Finding new, better ways in which people's recovery experiences can inform the growing evidence base is a challenge to which I hope I and other researchers can rise.

## References

- Barnao, M., Robertson, P. & Ward, T. (2010). Good Lives Model Applied to a Forensic Population. *Psychiatry, Psychology and Law*, 17(2), 202–217.
- Division of Clinical Psychology (DCP) (2014). *Understanding psychosis and schizophrenia*. Leicester: British Psychological Society.
- Harper, D. (2013). Reflections on qualitative research in clinical psychology training. *Clinical Psychology Forum*, (243), 20–23.
- Harper, D. & Speed, E. (2012). Uncovering recovery: the resistible rise of recovery and resilience. *Studies in Social Justice*, 6(1), 9–26.
- Hayes, S. C., Levin, M. E., Plumb-Villardaga, J. et al. (2013). Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy*, 44(2), 180–198.
- Hutton, P., Wood, L., Taylor, P. J. et al. (2013). Cognitive behavioural therapy for psychosis: rationale and protocol for a systematic review and meta-analysis. *Psychosis*, 6(3), 220–230.
- Jauhar, S., McKenna, P. J., Radua, J. et al. (2014). Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *The British Journal of Psychiatry*, 204(1), 20–29.
- Neech, S. (2014). *Involvement in a trainee clinical psychologist's thesis: What can service users and carers contribute as researchers and participants, and why should we listen?* Conference presentation at the British Psychological Society Division of Clinical Psychology Annual Conference, Glasgow, December 2014.
- NHS Education for Scotland. (2011). *The Matrix: A guide to delivering evidence-based psychological therapies in Scotland*. Edinburgh: Scottish Government.
- Roberts, G., & Boardman, J. (2013). Understanding “recovery.” *Advances in Psychiatric Treatment*, 19(6), 400–409.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Trafimow, D. & Marks, M. (2015). Editorial. *Basic and Applied Social Psychology*, 37(1), 1–2.
- Wells, T. (2010). *Applied psychologists and psychology in NHS Scotland*. Edinburgh: Scottish Government.

## References for full thesis

- Andresen, R., Caputi, P. & Oades, L. G. (2010). Do clinical outcome measures assess consumer-defined recovery? *Psychiatry Research*, 177(3), 309–317.
- Andresen, R., Oades, L. & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, 37(5), 586–594.
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11–23.
- Arboleda-Florez, J. & Stuart, H. (2012). From sin to science: Fighting the stigmatization of mental illnesses. *Canadian Journal of Psychiatry*, 57(8), 457–463.
- Arenella, J. (2015). Challenges for the recovery movement in the US: Will its light reach the darkest corners? *Clinical Psychology Forum* (268), 7–9.
- Armour, M. P., Bradshaw, W. & Roseborough, D. (2009). African Americans and recovery from severe mental illness. *Social Work in Mental Health*, 7(6), 602–622.
- Barker, C., Pistrang, N., & Elliott, R. (2002). Research methods in clinical psychology: An introduction for students and practitioners. Chichester: Wiley.
- Barnao, M., Robertson, P. & Ward, T. (2010). Good Lives Model Applied to a Forensic Population. *Psychiatry, Psychology and Law*, 17(2), 202–217.
- Barnao, M., Ward, T. & Casey, S. (2014). Looking Beyond the Illness: Forensic Service Users' Perceptions of Rehabilitation. *Journal of Interpersonal Violence* [Advance online publication]. doi: 10.1177/0886260514539764
- Beresford, P. (2015). From “recovery” to reclaiming madness. *Clinical Psychology Forum* (268), 16–20.
- Bird, V., Leamy, M., Tew, J., Boutillier, C. L., Williams, J., & Slade, M. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian and New Zealand Journal of Psychiatry* [Advance online publication]. <http://doi.org/10.1177/0004867413520046>
- Boeije, H. R., van Wesel, F., & Alisic, E. (2011). Making a difference: towards a method for weighing the evidence in a qualitative synthesis. *Journal of Evaluation in Clinical Practice*, 17(4), 657–663.
- Bonney, S. & Stickley, T. (2008). Recovery and mental health: a review of the British literature. *Journal of Psychiatric and Mental Health Nursing*, 15(2), 140–153.
- Borg, M. & Davidson, L. (2008). The nature of recovery as lived in everyday experience. *Journal of Mental Health*, 17(2), 129–140.
- Bradstreet, S. & McBrierty, R. (2012). Recovery in Scotland: beyond service development. *International Review of Psychiatry*, 24(1), 64–69.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Brijnath, B. (2015). Applying the CHIME recovery framework in two culturally diverse Australian communities: Qualitative results. *International Journal of Social Psychiatry* [Advance online publication]. <http://doi.org/10.1177/0020764015573084>
- British Psychological Society. (2012). *e –Professionalism: Guidance on the use of social media by clinical psychologists*. Leicester: Author.
- Brocki, J. M. & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health*, 21(1), 87–108.
- Browne, G. (2006). Outcome measures: Do they fit with a recovery model? *Australian & New Zealand Journal of Mental Health Nursing*, 15(2), 153–154.
- Brown, W. & Kandirikirira, N. (2007). *Recovering mental health in Scotland. Report on narrative investigation of mental health recovery*. Glasgow: Scottish Recovery Network. Available at <http://www.scottishrecovery.net/Download-document/193-Recovering-Mental-Health-in-Scotland.html>
- Burgess, S. L. H. (2011). *Exploring the experience of community adjustment following discharge from a low secure forensic unit*. Doctoral thesis, University of Leeds. Available at <http://etheses.whiterose.ac.uk/1741/>
- Burnard, P. (1994). Searching for meaning: a method of analysing interview transcripts with a personal computer. *Nurse Education Today*, 14(2), 111–117.

- Calvert, R. & Kellett, S. (2014). Cognitive analytic therapy: A review of the outcome evidence base for treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, 87(3), 253–277.
- Campbell, R., Pound, P., Pope, C. et al. (2003). Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science & Medicine*, 56(4), 671–684.
- Carr, A. (1999). *The handbook of child and adolescent clinical psychology: A contextual approach*. London: Routledge.
- Carroll, C., Booth, A. & Cooper, K. (2011). A worked example of “best fit” framework synthesis: A systematic review of views concerning the taking of some potential chemopreventive agents. *BMC Medical Research Methodology*, 11(1), 29.
- Carroll, C., Booth, A., Leaviss, J. & Rick, J. (2013). “Best fit” framework synthesis: refining the method. *BMC Medical Research Methodology*, 13. <http://doi.org/10.1186/1471-2288-13-37>
- Center for History and New Media. (2014). *Zotero* (Version 4.0.23). Fairfax, VA: Center for History and New Media. Retrieved from <https://www.zotero.org>
- Chandley, M. & Rouski, M. (2014). Recovery, turning points and forensics: views from the ward in an English high secure facility. *Mental Health and Social Inclusion*, 18(2), 83–91.
- Chenail, R. J. (2011). Learning to appraise the quality of qualitative research articles: A contextualized learning object for constructing knowledge. *The Qualitative Report*, 16(1), 236–248.
- Coffey, M. (2012a). Negotiating identity transition when leaving forensic hospitals. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness & Medicine*, 16(5), 489–506.
- Coffey, M. (2012b). A risk worth taking? Value differences and alternative risk constructions in accounts given by patients and their community workers following conditional discharge from forensic mental health services. *Health, Risk & Society*, 14(5), 465–482.
- Connell, J., O’Cathain, A., & Brazier, J. (2014). Measuring quality of life in mental health: Are we asking the right questions? *Social Science & Medicine*, 120, 12–20.
- Cooke, A., Smith, D. & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research*, 22(10), 1435–1443.
- Cook, J. A., Copeland, M. E., Hamilton, M. M. et al. (2009). Initial outcomes of a mental illness self-management program based on wellness recovery action planning. *Psychiatric Services*, 60(2), 246–249.
- Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training*, 41(4), 412–425.
- Cozzarelli, C., Karafa, J. A., Collins, N. L. & Tagler, M. J. (2003). Stability and change in adult attachment styles: associations with personal vulnerabilities, life events and global construals of self and others. *Journal of Social and Clinical Psychology*, 22(3), 315–346.
- Crichton, J. H., Darjee, R., McCall-Smith, A. & Chiswick, D. (2001). Mental Health (Public Safety and Appeals) (Scotland) Act 1999: detention of untreatable patients with psychopathic disorder. *The Journal of Forensic Psychiatry*, 12(3), 647–661.
- Crisford, H., Dare, H. & Evangeli, M. (2008). Offence-related posttraumatic stress disorder (PTSD) symptomatology and guilt in mentally disordered violent and sexual offenders. *The Journal of Forensic Psychiatry & Psychology*, 19(1), 86–107.
- Critical Appraisal Skills Programme (CASP). (2013, May 31). CASP qualitative research checklist. CASP. Available at <http://www.casp-uk.net/>
- Davidson, L., Borg, M., Mann, I. et al. (2005). Processes of Recovery in Serious Mental Illness: Findings from a Multinational Study. *Psychiatric Rehabilitation Skills*, 8(3), 177–201.
- Davidson, L., O’Connell, M., Tondora, J. et al. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, 57(5), 640–645.
- Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16(4), 459–470.
- Davidson, L. & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, 65(2), 131–145.
- Davies, S., Clarke, M., Hollin, C. & Duggan, C. (2007). Long-term outcomes after discharge from medium secure care: a cause for concern. *The British Journal of Psychiatry*, 191(1), 70–74.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11–19.

- Dixon-Woods, M. (2011). Using framework-based synthesis for conducting reviews of qualitative studies. *BMC Medicine*, 9(1), 39.
- Dixon-Woods, M., Agarwal, S., Jones, D. et al. (2005). Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of Health Services Research & Policy*, 10(1), 45–53.
- Dixon-Woods, M., Bonas, S., Booth, A. et al. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*, 6(1), 27–44.
- Dixon-Woods, M., Shaw, R. L., Agarwal, S. & Smith, J. A. (2004). The problem of appraising qualitative research. *Quality & Safety in Health Care*, 13(3), 223–225.
- Dixon-Woods, M., Sutton, A., Shaw, R. et al. (2007). Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *Journal of Health Services Research & Policy*, 12(1), 42–47.
- Division of Clinical Psychology (DCP) (2014). *Understanding psychosis and schizophrenia*. Leicester: British Psychological Society.
- Dohrenwend, B. P. (2000). The role of adversity and stress in psychopathology: some evidence and its implications for theory and research. *Journal of Health and Social Behavior*, 41(1), 1–19.
- Dorkins, E. & Adshead, G. (2011). Working with offenders: challenges to the recovery agenda. *Advances in Psychiatric Treatment*, 17(3), 178–187.
- Drennan, G. & Aldred, D. (2012a). Recovery in forensic mental health settings: from alienation to integration. In G. Drennan & D. Aldred (Eds.), *Secure recovery: Approaches to recovery in forensic mental health settings* (pp. 1–22). Oxon: Routledge.
- Drennan, G. & Aldred, D. (Eds.). (2012b). *Secure recovery: Approaches to recovery in forensic mental health settings*. Oxon: Routledge.
- Elliott, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215–229.
- Eriksen, K. Å., Arman, M., Davidson, L., Sundfør, B., & Karlsson, B. (2014). Challenges in relating to mental health professionals: Perspectives of persons with severe mental illness. *International Journal of Mental Health Nursing*, 23(2), 110–117.
- Estabrooks, C. A., Field, P. A. & Morse, J. M. (1994). Aggregating Qualitative Findings: An Approach to Theory Development. *Qualitative Health Research*, 4(4), 503–511.
- Farrall, S., Lightowler, C., McNeill, F. & Maruna, S. (2013). *Discovering desistance: Provocative propositions for reconfiguring social justice*. Available at <http://blogs.iriss.org.uk/discoveringdesistance/files/2013/08/DesKE-Propositions.pdf>
- Gilmartin, R. M. (1997). Personal narrative and the social reconstruction of the lives of former psychiatric patients. *J.Soc. & Soc. Welfare*, 24, 77–102.
- Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, 8(4), 597–607.
- Gray, N. S., Carman, N. G., Rogers, P. et al. (2003). Post-traumatic stress disorder caused in mentally disordered offenders by the committing of a serious violent or sexual offence. *The Journal of Forensic Psychiatry & Psychology*, 14(1), 27–43.
- Grayson, L. & Gomersall, A. (2003). *A difficult business: finding the evidence for social science reviews*. London: ESRC UK Centre for Evidence Based Policy and Practice, Queen Mary University of London. Available at <http://www.kcl.ac.uk/sspp/departments/politicaconomy/research/cep/pubs/papers/assets/wp19.pdf>
- Green, T., Batson, A. & Gudjonsson, G. (2011). The development and initial validation of a service-user led measure for recovery of mentally disordered offenders. *Journal of Forensic Psychiatry & Psychology*, 22(2), 252–265.
- Gudjonsson, G. H., Savona, C. S. V., Green, T. & Terry, R. (2011). The recovery approach to the care of mentally disordered patients. Does it predict treatment engagement and positive social behaviour beyond quality of life? *Personality and Individual Differences*, 51(8), 899–903.
- Gudjonsson, G. H., Webster, G. & Green, T. (2010). The recovery approach to care in psychiatric services: staff attitudes before and after training. *The Psychiatrist*, 34(8), 326–329.
- Gumley, A., Braehler, C., Laithwaite, H. et al. (2010). A Compassion Focused Model of Recovery after Psychosis. *International Journal of Cognitive Therapy*, 3(2), 186–201. <http://doi.org/10.1521/ijct.2010.3.2.186>



- Gumley, A., & Schwannauer, M. (2006). *Staying well after psychosis: A cognitive interpersonal approach to recovery and relapse prevention (Vol. xvi)*. New York, NY, US: John Wiley & Sons Ltd.
- Hagan, T. & Smail, D. (1997a). Power-mapping—I. Background and basic methodology. *Journal of Community & Applied Social Psychology*, 7(4), 257–267.
- Hagan, T. & Smail, D. (1997b). Power-mapping—II. Practical application: the example of child sexual abuse. *Journal of Community & Applied Social Psychology*, 7(4), 269–284.
- Harden, A. (2010) *Mixed-methods systematic reviews: integrating quantitative and qualitative findings*. Focus: A Publication of the National Center for the Dissemination of Disability Research (NCDDR) Technical Brief. Available at [http://ktdrr.org/ktdrr/articles\\_pubs/ncddrwork/focus/focus25/Focus25.pdf](http://ktdrr.org/ktdrr/articles_pubs/ncddrwork/focus/focus25/Focus25.pdf)
- Harper, D. (2013). Reflections on qualitative research in clinical psychology training. *Clinical Psychology Forum* (243), 20–23.
- Harper, D. & Speed, E. (2012). Uncovering recovery: the resistible rise of recovery and resilience. *Studies in Social Justice*, 6(1), 9–26.
- Hayes, S. C., Levin, M. E., Plumb-Villardaga, J. et al. (2013). Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy*, 44(2), 180–198.
- Hayes, S. C., Luoma, J. B., Bond, F. W. et al. (2006). Acceptance and Commitment Therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, 44(1), 1–25.
- Hayes, S. C. & Pierson, H. (2005). Acceptance and commitment therapy. In A. Freeman, S. H. Felgoise, C. M. Nezu, A. M. Nezu, & M. A. Reinecke (Eds.), *Encyclopedia of cognitive behavior therapy* (pp. 1–4). New York: Springer.
- Hefferon, K. & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis. *Psychologist*, 24(10), 756–759.
- Hellawell, S. J. & Brewin, C. R. (2004). A comparison of flashbacks and ordinary autobiographical memories of trauma: content and language. *Behaviour Research and Therapy*, 42(1), 1–12.
- Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377–391.
- Hirschi, T. (2002). *Causes of delinquency*. New Brunswick, N.J.: Transaction.
- Howells, K. (2010). The “third wave” of cognitive-behavioural therapy and forensic practice. *Criminal Behaviour and Mental Health*, 20(4), 251–256.
- Hutton, P., Wood, L., Taylor, P. J. et al. (2013). Cognitive behavioural therapy for psychosis: rationale and protocol for a systematic review and meta-analysis. *Psychosis*, 6(3), 220–230.
- Jacques, J., Spencer, S. & Gilluley, P. (2010). Long-term care needs in male medium security. *The British Journal of Forensic Practice*, 12(3), 37–44.
- Jamieson, L., Taylor, P. J. & Gibson, B. (2006). From pathological dependence to healthy independence: An emergent grounded theory of facilitating independent living. *The Grounded Theory Review*, 6(1), 79–108.
- Jauhar, S., McKenna, P. J., Radua, J. et al. (2014). Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *The British Journal of Psychiatry*, 204(1), 20–29.
- Jensen, L. W. & Wadkins, T. A. (2007). Mental health success stories: Finding paths to recovery. *Issues in Mental Health Nursing*, 28(4), 325–340.
- Johnson, B. & Montgomery, P. (1999). Chronic mentally ill individuals reentering the community after hospitalization. Phase II: The urban experience. *Journal of Psychiatric and Mental Health Nursing*, 6(6), 445–451.
- Kabat-Zinn, J. (2003). Mindfulness-Based Interventions in Context: Past, Present, and Future. *Clinical Psychology: Science and Practice*, 10(2), 144–156.
- Laithwaite, H. & Gumley, A. (2007). Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting. *Clinical Psychology & Psychotherapy*, 14(4), 302–316.
- Langan, J. (2010). Challenging assumptions about risk factors and the role of screening for violence risk in the field of mental health. *Health, Risk & Society*, 12(2), 85–100.
- Leamy, M., Bird, V., Le Boutillier, C. et al. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry*, 199(6), 445–452.
- Line, R., Marsh, L. & Cooke, S. (2014). Steps beyond: Reflections on a post-therapy group developed in partnership. *Clinical Psychology Forum* (260), 25–28.

- Lundgren, T., Luoma, J. B., Dahl, J. et al. (2012). The Bull's-Eye Values Survey: A Psychometric Evaluation. *Cognitive and Behavioral Practice*, 19, 518–526.
- MacInnes, D., Beer, D., Keeble, P. et al. (2011). Service-user involvement in forensic mental health care research: Areas to consider when developing a collaborative study. *Journal of Mental Health*, 20(5), 464–472.
- Maden, A., Rutter, S., McClintock, T. et al. (1999). Outcome of admission to a medium secure psychiatric unit. I: Short-and long-term outcome. *The British Journal of Psychiatry*, 175(4), 313–316.
- Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358(9280), 483–488.
- Mann, B., Matias, E. & Allen, J. (2014). Recovery in forensic services: Facing the challenge. *Advances in Psychiatric Treatment*, 20(2), 125–131.
- Marin, I., Mezzina, R., Borg, M. et al. (2005). The Person's Role in Recovery. *Psychiatric Rehabilitation Skills*, 8(3), 223–242.
- Maruna, S. (2001). *Making good: How ex-convicts reform and reclaim their lives*. Washington, D.C.: American Psychological Association.
- Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50(4), 370–396.
- McKirdy, J. (2015). Patient and public involvement in research. *DCP-S Review* (11), 15–17.
- Mezey, G. C., Kavuma, M., Turton, P. et al. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *Journal of Forensic Psychiatry and Psychology*, 21(5), 683–696.
- Mezey, G. & Eastman, N. (2009). Choice and social inclusion in forensic psychiatry: acknowledging mixed messages and double think. *The Journal of Forensic Psychiatry & Psychology*, 20(4), 503–508.
- Midlands Psychology Group. (2012). Draft manifesto for a social materialist psychology of distress. *Journal of Critical Psychology, Counselling and Psychotherapy*, 12(2), 93–107.
- Monger, B., Hardie, S. M., Ion, R. et al. (2013). The Individual Recovery Outcomes Counter: preliminary validation of a personal recovery measure. *The Psychiatrist*, 37(7), 221–227.
- Mullen, P. E. (2000). Forensic mental health. *The British Journal of Psychiatry*, 176(4), 307–311.
- Neech, S. (2014). *Involvement in a trainee clinical psychologist's thesis: What can service users and carers contribute as researchers and participants, and why should we listen?* Conference presentation at the British Psychological Society Division of Clinical Psychology Annual Conference, Glasgow, December 2014.
- NHS Education for Scotland. (2011). *The Matrix: A guide to delivering evidence-based psychological therapies in Scotland*. Edinburgh: Scottish Government.
- Nijdam-Jones, A., Livingston, J. D., Verdun-Jones, S. & Brink, J. (2014). Using social bonding theory to examine “recovery” in a forensic mental health hospital: A qualitative study. *Criminal Behaviour and Mental Health* [Advance online publication]. doi:10.1002/cbm.1918
- Ochocka, J., Nelson, G., & Janzen, R. (2005). Moving Forward: Negotiating Self and External Circumstances in Recovery. *Psychosocial Rehabilitation Journal*, 28(4), 315–322.
- Onken, S. J., Craig, C. M., Ridgway, P. et al. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychosocial Rehabilitation Journal*, 31(1), 9–22.
- O'Sullivan, M., Boulter, S. & Black, G. (2013). Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study. *Journal of Forensic Psychiatry & Psychology*, 24(3), 1–18.
- Paden, S. (2010). *Recovery and forensics – a tricky balancing act*. Available at <http://www.scottishrecovery.net/Submitted-thoughts-and-stories/recovery-and-forensics-a-tricky-balancing-act.html>
- Palermo, G. B. (2014). The Mentally Ill Offender: Failed Reintegration and Recidivism. *International Journal of Offender Therapy and Comparative Criminology*, 58(7), 763–764.
- Papaioannou, D., Sutton, A., Carroll, C. et al. (2010). Literature searching for social science systematic reviews: consideration of a range of search techniques. *Health Information & Libraries Journal*, 27(2), 114–122.
- Pesola, F., Williams, J., Bird, V. et al. (2015). Development and evaluation of an Individualized Outcome Measure (IOM) for randomized controlled trials in mental health. *International Journal of Methods in Psychiatric Research* [Advance online publication]. <http://doi.org/10.1002/mpr.1480>

- Piat, M., Sabetti, J., Couture, A. et al. (2009). What does recovery mean for me? Perspectives of Canadian mental health consumers. *Psychosocial Rehabilitation Journal*, 32(3), 199–207.
- Pilgrim, D. (2008). “Recovery” and current mental health policy. *Chronic Illness*, 4(4), 295–304.
- Pitt, L., Kilbride, M., Nothard, S. et al. (2007). Researching recovery from psychosis: A user-led project. *The Psychiatric Bulletin, The Psychiatrist*, 31(2), 55–60.
- Plumb, J. C., Stewart, I., Dahl, J. & Lundgren, T. (2009). In search of meaning: Values in modern clinical behavior analysis. *The Behavior Analyst*, 32(1), 85.
- Poortman, C. & Schildkamp, K. (2012). Alternative quality standards in qualitative research? *Quality & Quantity*, 46(6), 1727–1751.
- QSR International Pty Ltd. (2014) *NVivo qualitative data analysis software, Version 10*. Doncaster, Victoria: Author. Retrieved from <http://www.qsrinternational.com>.
- Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience. *Psychologist*, 18(1), 20–23.
- Rethink. (2005). *A Report on the Work of the Recovery Learning Sites and other Recovery-orientated activities and its incorporation into The Rethink Plan 2004-08*. Birmingham: Rethink.
- Rhodes, P. & De Jager, A. (2013). Narrative studies of recovery: A critical resource for clinicians. *Clinical Psychologist*, 18(3), 99–107.
- Roberts, G. (2011). “Forensic service user”: transitional identity or life sentence? *Advances in Psychiatric Treatment*, 17(3), 188–190.
- Roberts, G. & Boardman, J. (2013). Understanding “recovery.” *Advances in Psychiatric Treatment*, 19(6), 400–409.
- Robertson, P., Barnao, M. & Ward, T. (2011). Rehabilitation frameworks in forensic mental health. *Aggression and Violent Behavior*, 16(6), 472–484.
- Romme, M., Escher, S., Dillon, J. et al. (2009). *Living with voices: Fifty stories of recovery*. Ross-on-Wye, UK: PCCS Books.
- Rose, D. (2014). The mainstreaming of recovery. *Journal of Mental Health*, 23(5), 217–218.
- Roychowdhury, A. (2011). Bridging the gap between risk and recovery: a human needs approach. *The Psychiatrist*, 35(2), 68–73.
- Ryle, A. & Kerr, I. B. (2002). *Introducing cognitive analytic therapy: Principles and practice*. Chichester: John Wiley & Sons.
- Schwartz, S. (2012). Toward refining the theory of basic human values. In S. Salzborn, E. Davidov, and J. Reinecke (Eds.) *Methods, theories, and empirical applications in the social sciences* (pp. 39–46). New York: Springer.
- Schwartz, S. H. (2011). Studying values: Personal adventure, future directions. *Journal of Cross-Cultural Psychology*, 42(2), 307–319.
- Schwartz, S. H. & Bardi, A. (2001). Value Hierarchies Across Cultures Taking a Similarities Perspective. *Journal of Cross-Cultural Psychology*, 32(3), 268–290.
- Scottish Government. (2005). *National Programme for Improving Mental Health and Well-Being: Addressing Mental Health Inequalities in Scotland – Equal Minds*. Edinburgh: Author.
- Scottish Government (2012). *Mental Health Strategy for Scotland: 2012-2015*. Edinburgh: Author. Available at <http://www.gov.scot/Publications/2012/08/9714>
- Scottish Intercollegiate Guidelines Network (SIGN). (2014). *SIGN 50: a guideline developer’s handbook*. Edinburgh: Author. Available at <http://www.sign.ac.uk>
- Scottish Office (1999). *Health, social work and related services for mentally disordered offenders in Scotland*. Edinburgh: HMSO.
- Scottish Parliament (2013). *Social Care (Self-directed Support) (Scotland) Act 2013*. Edinburgh and Norwich: The Stationery Office.
- Shanks, V., Williams, J., Leamy, M., Bird, V. J., Le Boutillier, C., & Slade, M. (2013). Measures of personal recovery: A systematic review. *Hospital & Community Psychiatry*, 64(10), 974–980.
- Shepherd, A. (2013). The need for inclusion of concepts of recovery in clinical trials. *The British Journal of Psychiatry*, 202(2), 153–153.
- Silverstein, S. M. & Bellack, A. S. (2008). A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clinical Psychology Review*, 28(7), 1108–1124.
- Simpson, A. I. F. & Penney, S. R. (2011). The recovery paradigm in forensic mental health services. *Criminal Behaviour and Mental Health*, 21(5), 299–306.
- Slade, M. (2002). What outcomes to measure in routine mental health services, and how to assess them: a systematic review. *Australian and New Zealand Journal of Psychiatry*, 36(6), 743–753.

- Slade, M., Amering, M., Farkas, M. et al. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1), 12–20.
- Slade, M., Bird, V., Le Boutillier, C. et al. (2011). REFOCUS Trial: protocol for a cluster randomised controlled trial of a pro-recovery intervention within community based mental health teams. *BMC Psychiatry*, 11(1), 185.
- Slade, M., Bird, V., Clarke, E. et al. (2015). Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): a multisite, cluster, randomised, controlled trial. *The Lancet Psychiatry*, 2(6), 503–514.
- Slade, M., Leamy, M., Bacon, F. et al. (2012). International differences in understanding recovery: Systematic review. *Epidemiology and Psychiatric Sciences*, 21(4), 353–364.
- Slade, M., Williams, J., Bird, V. et al. (2012). Recovery grows up. *Journal of Mental Health*, 21(2), 99–103.
- Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39–54.
- Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5(1), 9–27.
- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Smith, J. & Garcia, V. (2012). Recovering personhood: Using recovery principles on a long-stay medium secure ward. In G. Drennan & D. Aldred (Eds.), *Secure recovery: Approaches to recovery in forensic mental health settings* (pp. 103–114). Oxon: Routledge.
- Smith-Merry, J., Freeman, R. & Sturdy, S. (2011). Implementing recovery: An analysis of the key technologies in Scotland. *International Journal of Mental Health Systems*, 5(11). Online. Retrieved from <http://www.ijmhs.com/content/5/1/11>
- Smith, M. K. (2000). Recovery from a severe psychiatric disability: Findings of a qualitative study. *Psychiatric Rehabilitation Journal*, 24(2), 149–158.
- Smyth, G., Harries, P. & Dorer, G. (2011). Exploring mental health service users' experiences of social inclusion in their community occupations. *The British Journal of Occupational Therapy*, 74(7), 323–331.
- Spaniol, L., Wewiorski, N. J., Gagne, C. & Anthony, W. A. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry*, 14(4), 327–336.
- Starks, H. & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372–1380.
- Stemler, S. E. (2004). A comparison of consensus, consistency, and measurement approaches to estimating interrater reliability. *Practical Assessment, Research & Evaluation*, 9(4), 66–78.
- Stickley, T. & Wright, N. (2011). The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part One: a review of the peer-reviewed literature using a systematic approach. *Journal of Psychiatric and Mental Health Nursing*, 18(3), 247–256.
- Thomas, J. & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8(1), 45.
- Thorne, S., Jensen, L., Kearney, M. et al. (2004). Qualitative metasynthesis: reflections on methodological orientation and ideological agenda. *Qualitative Health Research*, 14(10), 1342–1365.
- Thornhill, H., Clare, L. & May, R. (2004). Escape, enlightenment and endurance: Narratives of recovery from psychosis. *Anthropology and Medicine*, 11(2), 181–199.
- Thornton, T. & Lucas, P. (2011). On the very idea of a recovery model for mental health. *Journal of Medical Ethics*, 37(1), 24–28.
- Tong, A., Sainsbury, P. & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349–357.
- Tooth, B., Kalyanasundaram, V., Glover, H. & Momenzadah, S. (2003). Factors consumers identify as important to recovery from schizophrenia. *Australasian Psychiatry*, 11, S70–S77.
- Topor, A., Borg, M., Di Girolamo, S. & Davidson, L. (2011). Not just an individual journey: social aspects of recovery. *International Journal of Social Psychiatry*, 57(1), 90–99.
- Trafimow, D. & Marks, M. (2015). Editorial. *Basic and Applied Social Psychology*, 37(1), 1–2.

- Turton, P., Demetriou, A., Boland, W. et al. (2011). One size fits all: or horses for courses? Recovery-based care in specialist mental health services. *Social Psychiatry and Psychiatric Epidemiology*, 46(2), 127–136.
- Veseth, M., Binder, P., Borg, M. & Davidson, L. (2012). Toward caring for oneself in a life of intense ups and downs: A reflexive-collaborative exploration of recovery in bipolar disorder. *Qualitative Health Research*, 22(1), 119–133.
- Walsh, D. & Downe, S. (2006). Appraising the quality of qualitative research. *Midwifery*, 22(2), 108–119.
- Warner, R. (2010). Does the scientific evidence support the recovery model? *The Psychiatrist*, 34(1), 3–5.
- Watkins, E. R. (2008). Constructive and unconstructive repetitive thought. *Psychological Bulletin*, 134(2), 163–206.
- Wells, T. (2010). *Applied psychologists and psychology in NHS Scotland*. Edinburgh: Scottish Government.
- Wenzlaff, R. M. & Wegner, D. M. (2000). Thought Suppression. *Annual Review of Psychology*, 51(1), 59–91.
- Williams, J., Leamy, M., Bird, V., Boutillier, C. L., Norton, S., Pesola, F., & Slade, M. (2015). Development and evaluation of the INSPIRE measure of staff support for personal recovery. *Social Psychiatry and Psychiatric Epidemiology*, 50(5), 777–786.
- Wilson, A. E. & Ross, M. (2001). From chump to champ: People's appraisals of their earlier and present selves. *Journal of Personality and Social Psychology*, 80(4), 572–584.
- Wilson, K. G., Sandoz, E. K., Kitchens, J. & Roberts, M. (2011). The Valued Living Questionnaire: Defining and measuring valued action within a behavioral framework. *The Psychological Record*, 60(2), 4.
- Witvliet, C. vanOyen, Knoll, R. W., Hinman, N. G. & DeYoung, P. A. (2010). Compassion-focused reappraisal, benefit-focused reappraisal, and rumination after an interpersonal offense: Emotion-regulation implications for subjective emotion, linguistic responses, and physiology. *The Journal of Positive Psychology*, 5(3), 226–242.
- Woldgabreal, Y., Day, A. & Ward, T. (2014). The community-based supervision of offenders from a positive psychology perspective. *Aggression and Violent Behavior*, 19(1), 32–41.
- Wolff, G., Pathare, S., Craig, T. & Leff, J. (1996). Public education for community care: a new approach. *British Journal of Psychiatry*, (168), 441–447.
- Wyder, M., & Bland, R. (2014). The Recovery Framework as a Way of Understanding Families' Responses to Mental Illness: Balancing Different Needs and Recovery Journeys. *Australian Social Work*, 67(2), 179–196.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215–228.

## Appendix 1

### The Journal of Psychiatric and Mental Health Nursing

Relevant information is included here, from the online guide for authors:

[http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1365-2850/homepage/ForAuthors.html](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2850/homepage/ForAuthors.html)

- The journal welcomes methodologically, ethically and theoretically rigorous original research (primary or secondary) which adds new knowledge to the field and advances the development of policy and practice in psychiatric and mental health nursing. We will consider research papers of up to 5,000 words and review papers of up to 7,000 words\*.

- In the text, cite the authors' names followed by the date of publication e.g., Bowers & Thompson (2013). Where there are three or more authors, the first author's name followed by *et al.* will suffice, e.g. Kennard *et al.* (2012). Where more than one reference is cited they should be listed in chronological order. Authors should use the examples given below for referencing style\*\*. References to personal communications or unpublished results should be in the text only i.e. (A.C. Bowers & J.M. Thompson pers. comm.) or (A.C. Bowers unpublished results). The editor and publisher recommend that citation of online published papers and other material should be done via a DOI (digital object identifier), which all reputable online published material should have.

\* The journal's editorial assistant confirmed to SRS by e-mail on 31.10.14 that this word limit excludes tables, figures and references. Should Table 2 be deemed too long, we would propose to the editor that a shortened version is included in print (e.g. removing Aims & Key Findings columns) but that the whole table is presented as supplementary online material.

\*\* No such examples are in fact given. The referencing has therefore been carried out in accordance with examples from the journal itself, assisted by use of the appropriate .CSL style information for the Zotero reference manager (<https://www.zotero.org/styles/journal-of-psychiatric-and-mental-health-nursing>); and with Harvard style as generally advised by Wiley Online: [https://authorservices.wiley.com/reference\\_text.asp](https://authorservices.wiley.com/reference_text.asp)

## Appendix 2

### Articles excluded from review based on full-text reading

Article	Reason for exclusion
Alverson, M., Becker, D.R., Drake, R.E., 1995. An ethnographic study of coping strategies used by people with severe mental illness participating in supported employment. <i>Psychiatric Rehabilitation Journal</i> , 18, 115–128.	Doesn't address recovery within a consumer paradigm. Also focused on interaction of employment with recovery.
Borge, L., Fagermoen, M.S., 2008. Patients' core experiences of hospital treatment: Wholeness and self-worth in time and space. <i>Journal of Mental Health</i> , 17, 193–205.	Not focused on people with SEMI.
Chadwick, P.K., 1997. Recovery from psychosis: Learning more from patients. <i>Journal of Mental Health</i> , 6, 577–588.	Doesn't contain primary-source interview data.
Cohen, O., 2005. How do we Recover? An Analysis of Psychiatric Survivor Oral Histories. <i>Journal of Humanistic Psychology</i> , 45, 333–354.	Not focused on people with SEMI; not all based on primary-source interview data.
Jenkins, J.H., Strauss, M.E., Carpenter, E.A., Miller, D., Floersch, J., Sajatovic, M., 2005. Subjective experience of recovery from schizophrenia-related disorders and atypical antipsychotics. <i>Int.J.Soc.Psychiatry</i> , 51, 211–227.	Does not contain any primary-source interview data (indeed, isn't a qualitative study).
Kartalova-O'Doherty, Y., Doherty, D.T., 2010. Recovering from recurrent mental health problems: Giving up and fighting to get better. <i>Australian &amp; New Zealand Journal of Mental Health Nursing</i> , 19, 3–15.	Not focused on people with SEMI.
Kartalova-O'Doherty, Y., Stevenson, C., Higgins, A., 2012. Reconnecting with life: a grounded theory study of mental health recovery in Ireland. <i>Journal of Mental Health</i> , 21, 135–143.	Slightly unclear sample; not focused on people with SEMI.
Kogstad, R.E., Ekeland, T.-J., Hummelvoll, J.K., 2011. In defence of a humanistic approach to mental health care: Recovery processes investigated with the help of clients' narratives on turning points and processes of gradual change. <i>J.Psychiatr.Ment.Health Nurs.</i> 18, 479–486.	Not based on primary-source interview data.

Mancini, M.A., 2007. A qualitative analysis of turning points in the recovery process. <i>Psychiatric Rehabilitation Skills</i> , 10, 223–244.	Is focused on peer-providers.
Marin, I., Mezzina, R., 2006. Subjective recovery. A pilot study on mental health recovery factors. <i>Rivista Sperimentale di Freniatria: La Rivista della Salute Mentale</i> , 130, 129–152.	Not available in English. (This was not apparent until the author attempted to obtain the full text, hence inclusion in this appendix.)
Michalak, E.E., Hole, R., Holmes, C., Velyvis, V., Austin, J., Pesut, B., Hou, S., 2012. Implication for psychiatric care of the word “recovery” in people with bipolar disorder. <i>Psychiatric Annals</i> , 42, 173–178.	Not peer-reviewed (confirmed in e-mail from journal staff, 26.11.14).
Noiseux, S., Ricard, N., 2005. Recovery from persons living with schizophrenia. <i>Perspective infirmiere : revue officielle de l'Ordre des infirmieres et infirmiers du Quebec</i> , 3, 10–12, 14–16, 18–1620 passim.	Not available in English. (This was not apparent until the author attempted to obtain the full text, hence inclusion in this appendix.)
Noiseux, S., Ricard, N., 2008. Recovery as perceived by people with schizophrenia, family members and health professionals: A grounded theory. <i>Int.J.Nurs.Stud.</i> 45, 1148–1162.	Fewer than 40% of the participants were service users.
Turton, P., Demetriou, A., Boland, W., Gillard, S., Kavuma, M., Mezey, G., Mountford, V., Turner, K., White, S., Zadeh, E., Wright, C., 2011. One size fits all: or horses for courses? Recovery-based care in specialist mental health services. <i>Soc.Psychiatry Psychiatr.Epidemiol.</i> 46, 127–136.	Two-thirds of participants were not people with SEMI.
Wood, L., Price, J., Morrison, A., Haddock, G., 2010. Conceptualisation of recovery from psychosis: A service-user perspective. <i>Psychiatrist</i> , 34, 465–470.	Three-quarters of participants were from an early-intervention service.



## Appendix 3

Bespoke quality assessment pro-forma

### Systematic review: Quality criteria

v2.0, November 2014

Simon Stuart, Trainee Clinical Psychologist

What do we know about how service-users with severe and enduring mental illness experience the process of recovery? A systematic review and best-fit framework synthesis of qualitative data.

	Quality criteria
1.	The research questions are clear.
2.	The research questions are suited to qualitative enquiry.
3.	The participants are appropriate to the research questions, and recruitment is clearly described.
4.	Contextual and reflexivity issues are acknowledged appropriately.
5.	Ethical issues are acknowledged appropriately.
6.	The method of data collection is appropriate to the research question, and is clearly described.
7.	The method of data analysis is appropriate to the research question, and is clearly described.
8.	The data analysis is rigorous and supports the interpretations made by the researchers.
9.	The findings are clearly stated and discussed in the wider context of the research.
10.	The paper offers a useful contribution to the knowledge base in this area.

**Details of paper being reviewed:**

<Full reference for paper in here>

**Reviewer:**

**Date:**

<b>1. The research questions are clear.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• Research goals are clearly delineated <i>and</i></li> <li>• Rationale is provided for asking this particular question in the wider research context</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• Research aims are described well enough to be understood by a reasonably well-informed reader <i>and</i></li> <li>• The study is broadly justified by the authors in the wider research context</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• Anything other than the above</li> </ul>

**Comments and observations:**

**Rating:**

<b>2. The research questions are suited to qualitative enquiry.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• The rationale for using a qualitative method to answer the particular research question or questions is clearly stated <i>and</i></li> <li>• That rationale is supported with recourse to the evidence base for qualitative methodology, either generally or focusing on a specific qualitative method</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• A rationale is provided for using qualitative methodology to answer the particular research question <i>and</i></li> <li>• The research seeks to interpret or illuminate behaviour or subjective experience</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• Anything other than the above</li> </ul>

**Comments and observations:**

**Rating:**

<b>3. The participants are appropriate to the research question, and recruitment is clearly described.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• There is a clear explanation of why this population/sample of participants was deemed appropriate <i>and</i></li> <li>• There is a clear description of how participants were recruited <i>and</i></li> <li>• The size of the sample is described in relation to what is deemed appropriate for the chosen method</li> </ul> <p><i>Additional information likely to suggest this criterion is well covered:</i></p> <ul style="list-style-type: none"> <li>• Any issues, problems or concerns around recruitment are described</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• The population/sample is justified in the context of the present study <i>and</i></li> <li>• There is an explanation of how participants were recruited <i>and</i></li> <li>• Sample size is described</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• Anything other than the above</li> </ul>

**Comments and observations:**

**Rating:**

<b>4. Contextual and reflexivity issues are acknowledged.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• The researchers' role, potential bias and potential influence are considered and discussed</li> </ul> <p><i>or</i></p> <ul style="list-style-type: none"> <li>• The relationship between the researcher and the participants is considered critically</li> </ul> <p><i>Additional information likely to suggest this criterion is well covered:</i></p> <ul style="list-style-type: none"> <li>• Any potentially salient events (interpersonal, social, political) during the study are acknowledged</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• The relationship between the researcher and the participants is at least acknowledged</li> </ul> <p><i>or</i></p> <ul style="list-style-type: none"> <li>• The importance of reflexivity within qualitative research is acknowledged and applied broadly to this particular study</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• There is no mention of any contextual or reflexivity issues</li> </ul>

**Comments and observations:**

**Rating:**

<b>5. Ethical issues are acknowledged appropriately.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• Possible ethical issues are acknowledged by the authors <i>or</i> it is made clear that the issue of ethical approval was discussed with the appropriate authority <i>and</i></li> <li>• The study is described as being ethically approved <i>or</i> it is made clear that ethical approval for the study was not required</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• The study is described as being ethically approved <i>or</i></li> <li>• It is made clear that ethical approval for the study was not required</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• There is no mention of ethical issues <i>or</i></li> <li>• Ethical issues are mentioned but it is not made clear whether ethical approval was sought or required</li> </ul>

**Comments and observations:**

**Rating:**

<b>6. The method of data collection is appropriate to the research question, and is clearly described.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• The method of data collection is justified: e.g. why “face-to-face interview” was chosen over other possible methods that might feasibly have answered the research question <i>and</i></li> <li>• The method of recording data is clear, e.g. “audio recording”</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• The method of data collection is made explicit (e.g. “face to face interview”) and appears to be an appropriate way to answer the research question</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• The method of data collection does not appear to be appropriate to the research question <i>or</i></li> <li>• The method of data collection is not described</li> </ul>

**Comments and observations:**

**Rating:**

<b>7. The method of data analysis is appropriate to the research question, and is clearly described.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• A method of data analysis (e.g. “interpretative phenomenological analysis”) is described and justified as appropriate to answer the specific research question, with recourse to the evidence base for that method <i>and</i></li> <li>• Data are analysed appropriately for the chosen method</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• A method of data analysis is described, with at least an acknowledgement of the evidence base for that method, and appears appropriate to answer the specific research question <i>and</i></li> <li>• Data are analysed appropriately for the chosen method</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• Anything other than the above</li> </ul>

**Comments and observations:**

**Rating:**



<b>8. The data analysis is rigorous and supports the interpretations made by the researchers.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• The evidence provided (e.g. multiple interview extracts, from different participants) appears sufficient <i>and</i></li> <li>• The authors use the evidence clearly and convincingly to support the themes or concepts that they propose <i>and</i></li> <li>• Analytical issues pertaining to the researcher's role/potential biases/etc are at least acknowledged</li> </ul> <p><i>Additional information likely to suggest this criterion is well covered:</i></p> <ul style="list-style-type: none"> <li>• Disconfirming evidence/negative cases/contradictory data are considered</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• The evidence provided appears representative <i>and</i></li> <li>• The authors use the evidence clearly to support the themes or concepts that they propose</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• Anything other than the above</li> </ul>

**Comments and observations:**

**Rating:**

<b>9. The findings are clearly stated and discussed in the wider context of the research.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• The findings from the analysis are clearly stated and are related by the authors to the research question <i>and</i></li> <li>• The findings are discussed in relation to the existing evidence base: how they support it, where they might differ, etc. <i>and</i></li> <li>• The credibility of the findings is considered, with reference to issues such as triangulation/respondent validation/input from a second analyst <i>and</i></li> <li>• Limitations of the study are acknowledged, with suggestions as to future research</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• The findings from the analysis are discussed in the context of the research question <i>and</i></li> <li>• The relationship between the findings and the existing evidence base is acknowledged <i>and</i></li> <li>• Limitations of the study are acknowledged</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• Anything other than the above</li> </ul>

**Comments and observations:**

**Rating:**

<b>10. The paper offers a useful contribution to the knowledge base in this area.</b>	
<b>++ Well covered</b>	<ul style="list-style-type: none"> <li>• The authors offer a convincing summary of how the findings might add usefully to existing clinical, academic or other knowledge</li> </ul>
<b>+ Adequately addressed</b>	<ul style="list-style-type: none"> <li>• The findings are likely to be interesting to clinicians, academics or others involved in the broad field <i>or</i></li> <li>• The findings are used to identify new directions for research</li> </ul>
<b>- Poorly addressed, not addressed or not reported</b>	<ul style="list-style-type: none"> <li>• Anything other than the above</li> </ul>

**Comments and observations:**

**Rating:**

<b>Overall rating of paper (based on mode of the above 10 criteria)</b>	
<b>++ Noteworthy</b>	
<b>+ Acceptable</b>	
<b>- Limited</b>	

## **Appendix 4**

### Qualitative Health Research (journal)

Relevant information is included here, from the online guides for authors:

[http://www.uk.sagepub.com/journalsProdDesc.nav?prodId=Journal200926;](http://www.uk.sagepub.com/journalsProdDesc.nav?prodId=Journal200926)

<http://qhr.sagepub.com/site/misc/qhrauthorinstructions.pdf>

- Qualitative Health Research (QHR) is an international, interdisciplinary, refereed journal for the enhancement of health care and furthering the development and understanding of qualitative research methods in health care settings. We welcome manuscripts in the following areas: the description and analysis of the illness experience, health and health-seeking behaviors, the experiences of caregivers, the sociocultural organization of health care, health care policy, and related topics.

- QHR adheres to the APA reference style (6th edition):

[http://www.uk.sagepub.com/repository/binaries/pdf/APA\\_reference\\_style.pdf](http://www.uk.sagepub.com/repository/binaries/pdf/APA_reference_style.pdf)

While no information is currently provided about predetermined word limits, previous guidance has stated:

- There is no predetermined word or page limit. Provided they are “tight” and concise, without unnecessary repetition and/or irrelevant data, manuscripts should be as long as they need to be:

[http://www.sagepub.com/upm-data/42790\\_QHR\\_Manuscript\\_Guidelines\\_SEP\\_2011.pdf](http://www.sagepub.com/upm-data/42790_QHR_Manuscript_Guidelines_SEP_2011.pdf)

## Appendix 5

### Semi-structured interview schedule

#### **General opening questions**

- Q When did you leave [REDACTED]?
- F How long had you been there?
- Q Can you tell me a little bit about how life's been since then?
- P Do you think things have been going well since, or not?

#### **Check participant happy to continue**

#### **Recovery**

- I'd like to ask you some questions about recovery. Is that OK?
- Q Is recovery something people have talked to you about already?
- Q **What does recovery mean to you?**
- P "To me it's about your strengths, and how you build on them over time – to lead the life you want to lead"
- Q Is recovery an important thing to you or not?
- Q **Do you feel you're recovering, or not?**
- F Can you tell me a little bit more about that?
- Q **Is there anything you feel is holding you back, or not?**
- P You might feel there's something other people are doing – or that there's something you're doing, or not doing?
- F Can you tell me a little bit more about ... ?

#### **Reflect back**

#### **Check participant happy to continue**

#### **Personal values**

- The next thing I'd like to ask about is your values – basically, the things that matter most to you in life.
- Q What would you say your values are?
- P Some of the ones people often say are family, friends, spirituality, relationships, work, community ...
- Q **Do you think any of your values are particularly important for your own recovery, or not?**
- F Can you tell me a little bit more about ... ?
- Q Do you feel that the way you're living now fits with your own values, or not?
- F Again, can you tell me a little bit more about ... ?

#### **Reflect back**

#### **Check participant happy to continue**

#### **Societal values**

- The last thing I'd like to discuss is how you feel all of this fits in to wider society.
- Q **Do you think that other people share your values, or not?**
- P What about the people living around you?
- P What about the rest of the city? The rest of the country?
- Q Do you feel that other people's values help you with your own recovery, or not?
- F Can you tell me a little bit more about ... ?

#### **Final reflection and summary**

#### **Next steps**

- How has it felt to talk to me about this today?
- Do you have any questions you'd like to ask me?
- If I have any questions in the next four weeks, would you be willing to meet again and talk some more, or not?

#### **Thank you!**

#### **Key**

Q Question (**bold type** denotes key research question)

F Follow-up

P Prompt

## Appendix 6

### Participant information sheet

Barriers to recovery in people discharged from a medium-secure unit – Participant Info. Sheet

v4, 18.04.14, page 1 of 2



### Participant Information Sheet “Barriers to recovery, in the words of former inpatients”

- We are inviting you to take part in a research study.
- First, we want to make sure that you understand what it is, and what it would involve.
- Please take time to look carefully at this information sheet. If you have any questions, you can ask a member of the [REDACTED] community team to tell you more. Or you can talk to Simon, the trainee clinical psychologist who is running the study.

---

#### What is the study about?

This study is about how people who have stayed at the [REDACTED] have found the move back into the community. In particular, it wants to look at “recovery” – how people go about living a meaningful life, and what might stop them doing that. It also wants to look at “values” – the things that matter to people the most.

#### Why have I been asked to take part?

You have been asked to take part because you have stayed at the [REDACTED] in the past, and are now living in the community.

#### Do I have to take part?

No, you don't. It is up to you. You can take time to think about it and talk to other people before you decide. Your decision will have no effect on the care you receive, or on your legal rights. If you do want to take part, we will ask you to sign a form to say you agree. Even then, you can change your mind at any time. You never have to give us a reason.

#### What will happen if I take part?

Simon, the researcher, will arrange to meet with you. He will ask you about what life has been like since you left the [REDACTED]. It is up to you how long this takes, but it should be no more than an hour. Simon will most likely meet you at one of the outpatient rooms at the [REDACTED], though it might be possible for him to visit you at your home should you prefer. You are welcome to have a friend or relative with you, although they will not be asked any questions.

Simon will record the interview on an encrypted digital recorder. He will store this securely in his office at the [REDACTED], and will type up the interview as soon as possible. The recording will then be deleted. Simon will read the interview transcript very carefully. Once he has spoken to a few people, he will be able to see if they have had similar experiences.

After reading back over the interview, Simon might think of more questions he would like to ask. He might then ask to meet you again to talk some more. This would be entirely up to you. A second meeting would only happen if both you and Simon thought it would be helpful.

Once the project is complete, the [REDACTED] community team will be able to provide you with a summary of it. You will also be able to access the full research write-up online if you want.

Please turn over ➡

**How much will be asked about my past?**

You do not have to talk about your past: e.g. things that happened before your stay at the [REDACTED].

Simon, the researcher, would like to be able to see the notes the [REDACTED] have about why you were admitted and how long you were there. This would help him understand more about why you were a patient. However, you do not have to agree to this. You can still take part in the study even if you say “no” to this.

**What are the possible benefits of taking part?**

The study is about listening to people’s experiences and views. By listening to what people say, we hope that we can help improve the kind of care the NHS offers. We also hope that anyone taking part will find it an interesting thing to do.

**What are the possible disadvantages and risks of taking part?**

If you choose to take part, we recognise that you are sharing your time with us. We would not want anyone to have to spend money travelling to a meeting with Simon. If you do not already have a bus pass, Simon can reimburse you up to £3.50 for your bus fare.

We do not think that taking part will make anyone upset or unhappy. However, if it did, Simon would let the community team know. They would be able to help.

There is the very small chance that someone might say something to make us think they were at risk: perhaps of hurting themselves, or hurting someone else. If this happened, Simon would inform the [REDACTED] team straight away. If you told Simon that you were involved in any criminal activity, he would also inform the [REDACTED] team.

**What if there is a problem?**

If you have any concerns at any time, please speak to any member of the [REDACTED] community team. You could also speak to your psychiatrist, or to your GP.

**Will my taking part in the study be kept confidential?**

All the information we collect will be kept private. Neither the interview recording, nor the transcript, will contain your real name. If you agree to take part, the community team and your psychiatrist will be told. We will also let your GP know.

The study is part of the researcher’s doctoral thesis in clinical psychology. When this is written up, it will be available to read through a University of Edinburgh website. Simon will also submit it to be published, so other psychologists and professionals can read it.

We would like to include examples of people’s exact words in the write-up. However, we will not use real names or exact ages. It should not be possible for anyone reading the study to work out someone’s identity from it. Simon will talk to you more about this if you want.

**Who has reviewed the study?**

A group called a Research Ethics Committee has looked at the study idea, to make sure it is being done well. The South-East Scotland Research Ethics Committee 01 has given permission for it to go ahead (ref: 14/SS/0007). The study also has permission from local NHS management and from senior [REDACTED] staff.

**If you have any questions, you can ask the community team to put you in touch with Simon, the researcher. Or you can contact him directly:**

Simon Stuart, Trainee Clinical Psychologist. Tel: [REDACTED]

**If you would like to discuss this study with someone independent of the research, please contact:** [REDACTED], Occupational Therapist, [REDACTED]

Tel: [REDACTED]. **Or you can speak to your Community Psychiatric Nurse (CPN).**

If you wish to make a complaint about the study please contact: NHS Lothian Complaints Team, 2nd Floor, Waverley Gate, 2 - 4 Waterloo Place, Edinburgh EH1 3EG

Tel: 0131 465 5708

E-mail [complaints.team@nhslothian.scot.nhs.uk](mailto:complaints.team@nhslothian.scot.nhs.uk)

Thank you for taking the time to read this information sheet.

## Appendix 7

### Consent form

Barriers to recovery in people discharged from a medium-secure unit – Participant Consent Form v3, 20.01.14, page 1 of 1



THE UNIVERSITY  
of EDINBURGH

## Consent Form



### **“Barriers to recovery, in the words of former inpatients”**

A study by Simon Stuart, Trainee Clinical Psychologist

**Your name:**

**Please initial box**

- I have read the information sheet about this study. I have had the chance to think about the study and to ask any questions. ☐
- I understand that taking part in the study is voluntary. I understand that I am free to withdraw at any time, without giving a reason. This will not affect my medical care or my legal rights. ☐
- I agree to the appropriate ☐ staff being told that I am taking part. I also agree to my GP being told that I am taking part. ☐
- I am happy for the researcher, Simon Stuart, to access electronic notes and information that the ☐ already holds in relation to my care. ☐
- I understand that relevant sections of my medical notes and data collected during the study may be looked at by the study researchers and individuals from the Sponsor (University of Edinburgh) or from the NHS organisation, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my record. ☐
- I agree to take part in the above study. ☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

1x copy to the participant  
1x copy to the researcher  
1x copy for the participant's clinical notes



## Appendix 8

### Ethical and other approval

#### Lothian NHS Board

#### South East Scotland Research Ethics Committee 01



Waverley Gate  
2-4 Waterloo Place  
Edinburgh  
EH1 3EG  
Telephone 0131 536 9000  
Fax 0131 465 5789

[www.nhslothian.scot.nhs.uk](http://www.nhslothian.scot.nhs.uk)

Date 21 January 2014  
Your Ref  
Our Ref

Mr Simon Stuart  
Trainee Clinical Psychologist  
NHS Lothian  
School of Health in Social Science  
University of Edinburgh, Teviot Place  
Edinburgh  
EH8 9AG

Enquiries to: Sandra Wyllie  
Extension: 35473  
Direct Line: 0131 465 5473  
Email: [Sandra.Wyllie@nhslothian.scot.nhs.uk](mailto:Sandra.Wyllie@nhslothian.scot.nhs.uk)

Dear Mr Stuart

**Study title:** What are the barriers to recovery perceived by people discharged from a medium-secure forensic unit? An interpretative phenomenological analysis

**REC reference:** 14/SS/0007

**IRAS project ID:** 139243

Thank you for your letter of 20 January 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Mrs Sandra Wyllie, [Sandra.Wyllie@nhslothian.scot.nhs.uk](mailto:Sandra.Wyllie@nhslothian.scot.nhs.uk).

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

#### Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).



INVESTORS  
IN PEOPLE



POSITIVE ABOUT  
DISABLED PEOPLE



Healthy  
Working  
Lives

Headquarters  
Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chair Mr Brian Houston  
Chief Executive Tim Davison  
*Lothian NHS Board is the common name of Lothian Health Board*



### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett ([catherineblewett@nhs.net](mailto:catherineblewett@nhs.net)), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Interview Schedules/Topic Guides		06 January 2014
Other: CV - Dr E Quayle		



Other: CV - Dr L Tansey		
Other: CV- S Stuart		
Other: Invite letter to Responsible Medical Officer and permission form	Version 2	29 November 2013
Other: Letter to Medical Officer	Version 2	29 November 2013
Participant Consent Form	Version 3	20 January 2014
Participant Information Sheet	Version 3	20 January 2014
Protocol	Version 2	07 December 2013
REC application		15 December 2013
Response to Request for Further Information		20 January 2014

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### After ethical review

##### Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

##### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review



<b>14/SS/0007</b>	<b>Please quote this number on all correspondence</b>
-------------------	---

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Janet Andrews', with a long horizontal flourish extending to the right.

**Dr Janet Andrews**  
**Chair**

Email: Sandra.Wyllie@nhslothian.scot.nhs.uk

*Enclosures:* "After ethical review – guidance for  
researchers"

*Copy to:* Professor Charlotte Clarke  
Karen Maitland, NHS Lothian

University Hospitals Division

Queen's Medical Research Institute  
47 Little France Crescent, Edinburgh, EH16 4TJ

FM/TM/approval

5 February 2014

Mr Simon Stuart  
School of Health in Social Science  
University of Edinburgh  
Teviot Place  
Edinburgh  
EH8 9AG

**NHS**

**Lothian**

Research & Development  
Room E1.12  
Tel: 0131 242 3330  
Fax: 0131 242 3343

Email:  
R&DOffice@nhslothian.scot.nhs.uk

Director: Professor David E Newby

Dear Mr Stuart

Lothian R&D Project No: 2014/0024

**Title of Research:** What are the barriers to recovery perceived by people discharged from a medium-secure forensic unit? An interpretative phenomenological analysis

REC No: 14/SS/0007

**Participant Information Sheet:**  
version 3 dated 20 January 2014

**Consent Form:**  
version 3 dated 20 January 2014

**Protocol:** version 2 dated 7 December 2013

I am pleased to inform you that this study has been approved for NHS Lothian and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS Lothian.

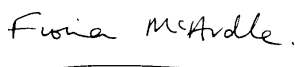
Please note that the NHS Lothian R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Lothian. This includes any changes made subsequent to management approval and prior to favourable opinion from the REC.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study.

Yours sincerely



Ms Fiona McArdle  
Deputy R&D Director

cc [REDACTED], Head of Service  
Paul Dearie, QA Manager  
Karen Maitland, Research Governance Manager

Lothian NHS Board

Waverley Gate  
2-4 Waterloo Place  
Edinburgh  
EH1 3EG  
Telephone 0131 465 5452  
Fax 0131 536 465 5494



[www.nhslothian.scot.nhs.uk](http://www.nhslothian.scot.nhs.uk)

Mr Simon Stuart



Date 19<sup>th</sup> June 2014  
Your Ref  
Our Ref CG/DF/1411  
Enquiries to Caldicott Office  
Extension 35452  
Direct Line 0131 465 5452  
Email [Caldicott.Guardian@nhslothian.scot.nhs.uk](mailto:Caldicott.Guardian@nhslothian.scot.nhs.uk)

Dear Mr Stuart

**CALDICOTT APPLICATION 1411**

Thank you for the information supplied

Request received from	Mr Simon Stuart
Summary of proposal	What are the barriers to recovery perceived by people discharged from a medium-secure forensic unit? An interpretative phenomenological analysis.
Patient identifiable information requested	Forename, Surname, Age, Other: length of time as an inpatient at the clinic, number of total admissions, reason for original admission (i.e. diagnosis and index-offence type)
Approved	YES
Advice	

Yours sincerely

**Professor Alison McCallum**  
**Director of Public Health & Health Policy**



Headquarters  
Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chair Mr Brian Houston  
Tim Davison, Chief Executive  
*Lothian NHS Board is the common name of Lothian Health Board*

## Lothian NHS Board

## South East Scotland Research Ethics Committee 01



Waverley Gate  
2-4 Waterloo Place  
Edinburgh  
EH1 3EG  
Telephone 0131 536 9000

[www.nhslothian.scot.nhs.uk](http://www.nhslothian.scot.nhs.uk)

Date 30 April 2014  
Your Ref  
Our Ref

Enquiries to: Sandra Wyllie  
Extension: 35473  
Direct Line: 0131 465 5473  
Email: [Sandra.Wyllie@nhslothian.scot.nhs.uk](mailto:Sandra.Wyllie@nhslothian.scot.nhs.uk)

Mr Simon Stuart  
Trainee Clinical Psychologist  
NHS Lothian  
School of Health in Social Science  
University of Edinburgh, Teviot Place  
Edinburgh  
EH8 9AG

Dear Mr Stuart

**Study title:** What are the barriers to recovery perceived by people discharged from a medium-secure forensic unit? An interpretative phenomenological analysis  
**REC reference:** 14/SS/0007  
**Amendment number:** 01  
**Amendment date:** 21 April 2014  
**IRAS project ID:** 139243

The above amendment was reviewed by the Sub-Committee in correspondence.

### Ethical opinion

The Sub Committee additionally requested reassurance that the participant will be asked for consent again just prior to the interview in their home, it was confirmed by the researcher that this would be the case.

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMPs)		21 April 2014
Participant Information Sheet	Version 4	18 April 2014
Protocol	Version 3	18 April 2014

### Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.



Headquarters  
Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chair Mr Brian Houston  
Chief Executive Tim Davison  
*Lothian NHS Board is the common name of Lothian Health Board*



**R&D approval**

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

<b>14/SS/0007:</b>	<b>Please quote this number on all correspondence</b>
--------------------	---

Yours sincerely

A handwritten signature in black ink, appearing to read 'Janet Andrews', with a long horizontal flourish extending to the right.

**Dr Janet Andrews**  
**Chair**

E-mail: Sandra.Wyllie@nhslothian.scot.nhs.uk

*Enclosures:*                      *List of names and professions of members who took part in the review*

*Copy to:*                          *Karen Maitland, NHS Lothian*  
   *Professor Charlotte Laura Clarke, University of Edinburgh*



University Hospitals Division

**Queen's Medical Research Institute**  
47 Little France Crescent, Edinburgh, EH16 4TJ



SS/NM

07 May 2014

Mr Simon Stuart  
School of Health in Social Science  
University of Edinburgh  
Teviot Place  
Edinburgh  
EH8 9AG

RESEARCH & DEVELOPMENT  
Room E1.12  
Tel: 0131 242 3330  
Fax: 0131 242 3343  
Email:  
R&DOffice@nhslothian.scot.nhs.uk

Director:  
Professor David E Newby

Dear Mr Stuart

<b>REC No:</b>	14/SS/0007
<b>R&amp;D Project ID No:</b>	2014/0024
<b>Amendment:</b>	Substantial amendment No.1 dated 18 April 2014
<b>Title of Research</b>	What are the barriers to recovery perceived by people discharged from a medium-secure forensic unit? An interpretative phenomenological analysis

I am writing in reply to recent correspondence in relation to an amendment(s) to the above project and the subsequent updated documents as follows.

- protocol version 3 - dated 18 April 2014
- Participant Information Sheet version 4 - dated 18 April 2014

We have now assessed any consequential changes and can confirm that NHS Lothian management approval is extended to cover the specific changes intimated.

Yours sincerely

A handwritten signature in black ink that reads 'Susan Shepherd'.

Mrs Susan Shepherd  
Head of Research Governance

cc: [REDACTED], Head of Service

## Appendix 9

### Transcription conventions

...	Brief pause in the person's speech, with no missing text
[...]	Part of the transcript has been omitted
[text]	Part of the transcript has been omitted; the text describes the omission. In some instances, e.g. [clinic], this convention is used to preserve anonymity
<text>	Non-lexical verbalisation, e.g. <sigh>
(text)	Another person (e.g. the interviewer) is speaking at the same time. Omitted content within their speech is denoted by further square brackets, e.g. ([agreement])
tex-	Word or sound is incomplete
SRS	Interviewer's initials
Px	Participant x

## Appendix 10

### Example of IPA transcript (single page from Microsoft Word)

Column 3 is the original transcript; column 4 contains the researcher's initial noting. Descriptive comments are in Roman type, linguistic comments are in italics, and conceptual comments (the majority) are underlined. Column 1 contains the initial emergent themes. Column 2 contains refined emergent themes, iteratively produced during the process of cross-case analysis as described in the Extended Method chapter.

<ul style="list-style-type: none"> <li>• Beating the system</li> <li>• Clarity of vision (re: MH system)</li> <li>• Superiority • Disbelief</li> </ul>	<p><b>Beating the system</b></p> <p><b>Clarity (enlightenment)</b></p> <p><b>Sense of superiority</b></p> <p><b>Services as ignorant</b></p> <p><b>Disbelief at services</b></p>	<p>medical thing I was looking at (laughter). A- ... the- di- ... she said, and then she told me she'd seen it on, the internet, she'd been like tha-, What? (Sniggering) This woman's looking up the internet for diagnoses (sic) that might fit me! Aren't you supposed to know what you're doing? So an' I ... so I literally came out and I'm sitting in the smoking room after it, and I'm just [sibilant noises of disbelief], a complete fucking waste of time! And this was in a rehab ward. Like, these people are looking up illnesses, that might fit me, just so they can say: that's what it was, that's what we treated you for. Now on you go. Why am I in rehab if you don't even know what ... 's wrong with me? You know, I was moving on from one rehab ward to the (mm-hm), to the final rehab ward, they w-, they'd already told me that. And yet they still hadn't worked out what they were actually treating me for. Which was <i>nothing</i>.</p> <p><b>And did they, did they ever, did they ever say to you, ah, we've worked this out, or ... or not?</b></p> <p>No, at that time they were saying there were nothing, re- , really wrong with me. But the Scottish Exec w-, wasn't having that. Cos they (aye) weren't wanting me leaving [first secure unit] without a proper diagnosis (yeh) that says, here's what we've treated this bloke for. And</p>	<p>somehow beaten/made a mockery of the system. Participant feels able to see through the system, see it for what it really is? Again, participant is superior to/cleverer than others? Breakdown in syntax: <i>disbelief?</i></p> <p>Dismissive of doctors for using the internet: suggests overvaluing of medical profession; lack of understanding of the realities of medicine and diagnosis.</p> <p>Past continuous again: <i>embellishment of narrative</i></p> <p>Repetition of waste of time. <i>Fucking: frustration, disbelief</i></p> <p>Reflection: services are trying to find a diagnosis so they can justify why I was there. (This is plausible.) On you go: <i>sense that service can't have achieved anything other than holding pt for a while and moving them on (language of dismissal)</i>; again, no sense of the complexity of secure care or of shifting diagnoses – was any effort made to communicate this to pt? What engagement was there with pt?</p> <p>Participant expecting discharge – still didn't have dx – sense of <i>incredulity at this</i></p> <p>Which was <i>nothing</i> – anger at this; sense that shouldn't have been in system at all, though alternative to this not acknowledged yet. <i>Nothing</i>: reassertion of wellness; reassertion of wellness throughout – IO was substance-related and pt. didn't need help – pt. is stronger than that?</p> <p>Nothing really wrong with me: <i>but something wrong?</i> Scottish Executive: bureaucratic (again, Kafka-esque) sense of having to find something in order to tick a box. Even the highest power doesn't get me/is wrong? Dismissal of traditional power structures.</p> <p>Timeline here is unclear: i.e. which unit the above refers to. (Line 525 suggests this is first unit, not ■■■.)</p>
<ul style="list-style-type: none"> <li>• Dismissive of services</li> <li>• Lack of understanding of medical system</li> </ul>	<p><b>Dismissing help (services)</b></p> <p><b>Uncertainty about how services work</b></p>		
<ul style="list-style-type: none"> <li>• Embellishment of narrative</li> </ul>	<p><b>Embellishment of narrative</b></p>		
<ul style="list-style-type: none"> <li>• Frustration • Disbelief</li> </ul>	<p><b>Frustration at services</b></p> <p><b>Disbelief at services</b></p>		
<ul style="list-style-type: none"> <li>• Dismissiveness of services</li> </ul>	<p><b>Dismissing help (services)</b></p>		
<ul style="list-style-type: none"> <li>• Lack of understanding of systems</li> <li>• Communication between system and px</li> </ul>	<p><b>Uncertainty about how services work</b></p> <p><b>Difficulty of communicating with services</b></p>		
<ul style="list-style-type: none"> <li>• Incredulity at MH system</li> <li>• Anger at treatment by system</li> <li>• Feeling badly treated</li> <li>• Assertion of wellness</li> <li>• Assertion of strength and power</li> </ul>	<p><b>Disbelief at services</b></p> <p><b>Anger at treatment by system</b></p> <p><b>Resentment at services</b></p> <p><b>Being well (assertion of)</b></p> <p><b>Being strong</b></p>		
<ul style="list-style-type: none"> <li>• Being unwell</li> <li>• Bureaucracy • Complex narrative</li> <li>• Box-ticking</li> <li>• Superiority (and power)</li> <li>• Dismissal (of power structures)</li> <li>• Lack of temporal clarity</li> </ul>	<p><b>Questions of mental illness</b></p> <p><b>Getting stuck in the system</b></p> <p><b>Complex narrative (experiences)</b></p> <p><b>Questions of power &amp; superiority</b></p> <p><b>Dismissal of power structures</b></p> <p><b>Temporal uncertainty</b></p>		

## **Appendix 11**

### Clinical Psychology Forum (journal)

Relevant information is included here, from the online guide for authors:

<http://www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/contributions-0>

- Clinical Psychology Forum (CPF) welcomes contributions which are original, innovative, authoritative and of interest to the membership of the Division. We aim to publish a variety of contributions ranging from personal reflections on clinical practice to critiques of current health policy, innovations in service development, and audit and research studies.
- Articles of 1000-2500 words including references are welcomed.
- Include a 40-word summary (maximum) at the beginning of the paper
- Give references in the format set out in the Society's Editorial Style Guide:  
[https://www.bps.org.uk/system/files/user-files/Society%20Member/2015style\\_guide\\_web.pdf](https://www.bps.org.uk/system/files/user-files/Society%20Member/2015style_guide_web.pdf)